AMENDED IN ASSEMBLY APRIL 28, 2003

CALIFORNIA LEGISLATURE—2003–04 FIRST EXTRAORDINARY SESSION

SENATE BILL No. 6

Introduced by Committee on Budget and Fiscal Review

January 27, 2003

~~An act to amend Section 39612 of, and to add Section 39613 to, the Health and Safety Code, relating to air pollution.~~ *An act to amend Section 17706 of the Family Code, to amend Sections 1266, 1523.1, 1523.2, 1568.05, 1569.185, 1596.803, 104322, 127880, and 127885 of, to add Article 7.5 (commencing with Section 1324) to Chapter 2 of Division 2 of, and to repeal and add Section 104181.5 of, the Health and Safety Code, and to amend Sections 11453, 11462, 11462.06, 11463, 11466.2, 11466.35, 12201, 12201.03, 14067, 14124.93, 14132, 14132.88, 14148.5, and 14154 of, to add Sections 4785 and 14043.26 to, and to add Chapter 13 (commencing with Section 4850) to Division 4.5 of, the Welfare and Institutions Code, relating to health and human services, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 6, as amended, ~~Senate~~ Committee on Budget and ~~Fund~~ *Fiscal* Review. ~~Air pollution: permit fees on nonvehicular sources~~ *Health and Human Services: Budget Act trailer.*

(1) Existing law requires the Department of Child Support Services to pay to each county a child support incentive payment to encourage child support enforcement efforts. Existing law requires the department to pay an additional incentive, from specified county collections, to the counties with the 10 best performance standards in certain child

support-related activities. Existing law suspends the operation of the provision requiring payment of this additional incentive for the 2002–03 fiscal year.

This bill would further suspend the operation of the provision requiring payment of the additional incentive for the 2003–04, 2004–05, and 2005–06 fiscal years.

(2) Existing law sets forth the licensing and renewal fee to be charged certain health facilities, as defined. The annual fee is waived for any health facility conducted, maintained, or operated by this state or any state department, authority, bureau, commission, or officer, by the Regents of the University of California, or by a local hospital district, city, county, or city and county. Existing law requires that the fees be adjusted annually, as directed by the Legislature in the annual Budget Act. Existing law requires that the methodology and calculations used to determine the fee amounts result in fee levels in an amount sufficient to provide revenues equal to the sum of various expenditures.

This bill would revise these provisions to, among other things, require that General Fund expenditures attributed to facilities exempt from paying the annual fee be included in calculations to establish fee levels to be charged to facilities required to pay the annual fee. The bill would also require, if the Budget Act provides for expenditures that differ by 5% from the Governor's proposed budget, the Department of Finance to adjust the fees to reflect that difference and to instruct the State of Department Health Services to publish those fees as prescribed. This bill would impose a state tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of $^2/_3$ of the membership of each house of the Legislature.

(3) Existing law provides for the regulation of health facilities, including intermediate care facilities, by the State Department of Health Services.

Existing law establishes the Medi-Cal program, administered by the department, under which health care services are provided to qualified low-income persons. Existing law authorizes the department to certify intermediate care facilities that meet certain requirements to participate in the Medi-Cal program.

This bill would, as a condition for participation in the Medi-Cal program, impose each year upon the gross receipts, as defined, of an intermediate care facility a quality assurance fee, to be paid to the

department and deposited in the General Fund. The bill would also provide for the supplemental reimbursement of these intermediate care facilities, and would require the department to seek federal approval for the implementation of these provisions. The bill would provide that these provisions shall become inoperative if federal approval is not obtained for implementation of the supplemental reimbursement provision or if certain judicial determinations or federal determinations are made that the supplemental reimbursement provision must be made to a facility not described under these provisions.

(4) Under existing law, the State Department of Social Services regulates the licensure and operation of various care facilities, including foster family and adoption agencies, adult day programs, child day care facilities, residential care facilities for the elderly, and residential care facilities for persons with chronic life-threatening illnesses. Existing law establishes licensure and renewal fees for these facilities, which are classified according to the facility's capacity.

This bill would increase the licensure and renewal fees for these facilities. The bill would also revise the facility capacity classifications for child day care centers.

(5) Under existing law, the Technical Assistance Fund consists of specified moneys to be expended, upon appropriation by the Legislature, to fund the creation and maintenance of new licensing staff positions to provide technical assistance to specified care facility licensees. Under existing law, in fiscal years when licensure fees collected by the department from the specified facilities exceed $6,000,000, the excess shall be expended by the department to fund these new positions.

This bill would provide that, notwithstanding existing law, when revenues in the fund exceed $3,237,000, any fees collected over that amount shall remain in the General Fund.

(6) Existing law provides that an appropriation is available for encumbrance during the period specified therein, or, if not otherwise limited by law, for 3 years after the date upon which it first became available for encumbrance. Subdivision (a) of Section 2.00 of the Budget Act of 2002 provides that appropriations in the act, unless otherwise provided, are appropriated for the use and support of the state for the 2002–03 fiscal year.

Existing law provides for a Cancer Research Program administered by the State Department of Health Services. Existing law prohibits the department, in awarding grants under this program, from encumbering

money allocated in any fiscal year other than the fiscal year in which the appropriation was made.

This bill would repeal this prohibition, and instead, commencing with the appropriation for the 2002–03 fiscal year, and for each fiscal year thereafter, would provide that the amount appropriated to the department for the Cancer Research Program is available for that program, for encumbrance for one fiscal year beyond the year of appropriation, and for expenditure for 3 fiscal years beyond the year of encumbrance, thereby making an appropriation.

(7) Existing law establishes the prostate cancer treatment program, administered by the department, under which one or more contracts may be entered into in order to provide prostate cancer treatment services to low-income uninsured and underinsured men.

This bill, commencing with the 2003–04 fiscal year, would require that the amount appropriated to the department for the prostate cancer treatment program be made available for that program, for encumbrance for one fiscal year beyond the year of appropriation, and for expenditure for 2 fiscal years beyond the year of encumbrance, thereby making an appropriation.

(8) Existing law provides that it is the intent of the Legislature to maintain a Health Professions Career Opportunity Program designed to increase the number of ethnic minorities in health professional training and to increase the number of health professionals practicing in health manpower shortage areas in this area.

This bill would specify that it is the intent of the Legislature to maintain this program subject to available funds.

(9) Existing law requires the Office of Statewide Health Planning and Development to maintain a Health Professions Career Opportunity Program.

This bill would require the office to maintain this program contingent upon an appropriation in the annual Budget Act or other statute.

(10) Under the Lanterman Developmental Disabilities Services Act (the act), services are provided to persons with developmental disabilities in state hospitals known as developmental centers operated by the State Department of Developmental Services.

Existing law requires nonprofit organizations, known as regional centers, to contract with the State Department of Developmental Services to provide services and support to persons with developmental disabilities.

Existing law requires parents of children under the age of 18 years who are receiving 24-hour out-of-home care services through a regional center, or who are residents of a state hospital or on leave from the state hospital, to pay a fee, depending upon their ability to pay, as specified. Existing law requires the State Department of Developmental Services to determine, assess, and collect all parental fees, as specified.

This bill would require the parent or parents of a child who is aged 3 to 17 years, inclusive, who resides in the parent's or parents' home and who receives services purchased through a regional center, to pay a copayment for the services provided to the child, unless the parent's income is below a specified amount. This bill would require the State Department of Developmental Services to administer this copayment program, determine copayment amounts, collect all copayments, and remit all payments to the State Treasury for deposit in the General Fund. It would also authorize the department to adopt regulations to implement these provisions.

(11) Existing law establishes the Habilitation Services Program under the administration of the Department of Rehabilitation.

This bill would transfer the administration of this program to the State Department of Developmental Services on July 1, 2003.

(12) Existing federal law provides for allocation of federal funds through the federal Temporary Assistance for Needy Families (TANF) block grant program to eligible states. Existing law provides for the California Work Opportunity and Responsibility to Kids (CalWORKs) program for the allocation of federal funds received through the TANF program, under which each county provides cash assistance and other benefits to qualified low-income families.

Existing law establishes maximum aid grant amounts to be provided under the CalWORKs program, and provides, with certain exceptions, that the aid grant amounts shall be adjusted annually to reflect any increases or decreases in the cost of living. Existing law provides that in any fiscal year commencing with the 2001–02 fiscal year through the 2003–04 fiscal year, when there is an increase in tax relief in the vehicle license fee, then the cost-of-living increase in CalWORKs maximum aid payment levels shall occur, and, with respect to any of those fiscal years where there is no vehicle license fee tax relief, any maximum aid payment level cost-of-living increase shall be suspended.

Existing law requires that a cost-of-living adjustment to the maximum aid payments be made for the 2002–03 fiscal year that would become effective June 1, 2003, notwithstanding the above provision.

This bill would prohibit any cost-of-living adjustment to the maximum aid payments to be made under the CalWORKs program for the 2002–03 and 2003–04 fiscal years.

(13) Existing law, pursuant to the Aid to Families with Dependent Children-Foster Care (AFDC-FC) program, requires that foster care providers licensed as group homes have rates established by classifying each group home program and applying the standardized schedule of rates. Existing law requires the State Department of Social Services to collect information from group providers in order to classify each group home program. Existing law also requires the department to develop, implement, and maintain a ratesetting system for foster family agencies. Group home and foster family agency ratesetting provisions contain annual cost-of-living adjustment requirements, as prescribed.

This bill would require the department to determine the rate classification level for each group home program and the rates for foster family agency programs on a biennial basis as prescribed. It would require the department to implement these requirements through the adoption of emergency regulations.

(14) Existing law, for purposes of administration of the AFDC-FC program, including the setting of group home rates, requires the State Department of Social Services to deem the reasonable costs of leases for shelter care for foster children to be allowable costs, and establishes a formula to determine the fair market value of owned, leased, or rented buildings.

Existing law provides that the allowable costs of affiliated leases shall be subject to review by the Charitable Trust Section of the Department of Justice, and shall be permitted to the extent allowed by federal law for federal financial participation. Existing law also requires, effective July 1, 1998, an approval letter from the Charitable Trust Section of the Department of Justice for approval of shelter costs that result from self-dealing transactions, as defined.

This bill would delete the provisions regarding allowable costs of affiliated leases and the requirement of an approval letter from the Department of Justice for approval of shelter costs that result from self-dealing transactions.

(15) Existing AFDC-FC provisions require the department to perform or have performed group home program and fiscal audits as needed.

This bill would provide that an audit period may be less than the period of time for which the rate is established.

(16) Existing law requires a licensee, who has been determined to owe a sustained overpayment under the AFDC-FC program, and who, subsequent to notice of the sustained overpayment, has its group home rate terminated, shall be ineligible to apply for, or receive, a rate for any future group home program until the overpayment is repaid.

Existing law requires that an annual rate application be denied for a group home provider that meets specified conditions with respect to owing or incurring a sustained overpayment.

This bill, instead, would provide that a rate application, rather than an annual rate application, be denied in these circumstances.

(17) Existing law provides for the state Supplementary Program for the Aged, Blind and Disabled (SSP), which requires the State Department of Social Services to contract with the United States Secretary of Health and Human Services to make payments to SSP recipients to supplement supplemental security income (SSI) payments made available pursuant to the federal Social Security Act.

Existing law provides for the annual adjustment of benefits under the SSP program based on changes in the cost of living, with certain exceptions, and specifies that the adjustment of the benefits shall become effective January 1 of each year. Existing law provides that for the 2003 calendar year, the cost-of-living adjustment shall become effective June 1, 2003.

This bill instead would prohibit any cost-of-living adjustment of benefits to be made for the 2003 and 2004 calendar years.

(18) Existing law provides that for calendar years 1992 to 1998, inclusive, or for the period of January 1, 2003, to May 31, 2003, inclusive, and commencing with the 2004 calendar year, and thereafter, if no cost-of-living adjustment is made, the SSP payment schedules shall include the pass along of any cost-of-living increases in federal benefits under the federal Social Security Act.

This bill would expand the application of the above provision to include all of calendar year 2003.

(19) Existing law imposes requirements with respect to the use of application forms for enrollment, provider agreements, and all attachments or changes to either under the Medi-Cal program, and requires that these forms and agreements be developed in accordance with the rulemaking provisions of the Administrative Procedure Act.

This bill would authorize the Director of Health Services, notwithstanding the Administrative Procedure Act, to develop application forms for enrollment and continued enrollment by dentists,

and to authorize the use of these forms upon publication in a provider bulletin or similar instruction.

(20) Existing law requires the State Department of Health Services to develop and conduct a community outreach and education campaign and, contingent upon appropriation, to award contracts to community-based organizations to help families learn about, and apply for, Medi-Cal and the Healthy Families Program.

This bill would, instead, authorize the department to perform these activities and would require implementation of the community outreach and education campaign upon appropriation for that purpose in the annual Budget Act or other statute.

(21) Existing law requires the Department of Child Support Services to provide payments to local child support agencies of $50 per case for obtaining 3rd-party health coverage or insurance of Medi-Cal beneficiaries, to the extent that funds are appropriated in the annual Budget Act.

This bill would suspend this requirement for the 2003–04, 2004–05, and 2005–06 fiscal years.

(22) Existing law provides for the provision of specified benefits to persons enrolled in the Medi-Cal program. Among these benefits are specified emergency and essential diagnostic and restorative dental services. Existing law prohibits the State Department of Health Services' utilization controls from requiring X-rays as a condition of reimbursement for fillings for children under 18 years of age.

This bill would delete this prohibition, and would make various revisions regarding covered dental benefits under the program.

(23) Existing law requires the State Department of Health Services, in implementing the Medi-Cal program and public health programs, to provide for outreach activities in order to enhance participation and access to perinatal services.

This bill would, instead, authorize the department to perform these outreach activities, and would require implementation of these activities upon an appropriation in the annual Budget Act or other statute for this purpose.

(24) Existing law requires the State Department of Health Services to establish and maintain a plan to effectively control costs for the county administration of the determination of eligibility for benefits under the Medi-Cal program so that the costs are within the amounts annually appropriated for that administration. The plan is required to establish standards and performance criteria.

This bill would require each county, in administering the Medi-Cal eligibility process, to meet specified performance standards each fiscal year, and report the county's performance on September 1 of each year. The bill would authorize the department, at its sole discretion, to reduce the allocation of funds as prescribed if a county does not meet the performance standards established by these provisions for eligibility determinations and redeterminations. By imposing new duties on counties with respect to the administration of the Medi-Cal program, this bill would impose a state-mandated local program.

(25) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

(26) This bill would declare that it is to take effect immediately as an urgency statute.

~~(1) Existing law designates air pollution control districts and air quality management districts as having the primary responsibility for the control of air pollution from all sources other than vehicular sources. Existing law authorizes each district to establish a permit system that requires, except as specified, that before any person builds, erects, alters, replaces, operates, or uses any article, machine, equipment, or other contrivance that may cause the issuance of air contaminants, the person obtain a permit from the air pollution control officer of the district. Existing law also authorizes each district board to adopt, by regulation, a schedule of annual fees for the evaluation, issuance, and renewal of those permits. Existing law authorizes the State Air Resources Board to require districts to impose additional permit fees on nonvehicular sources within their jurisdiction for the purposes of recovering costs of additional state programs related to those sources. Existing law requires that priority for expenditure of those permit fees be given to specified activities relating to air pollution from nonvehicular sources, and requires that those permit fees be collected from nonvehicular sources that are authorized by district permits to~~

~~emit 500 tons or more per year of any nonattainment pollutant or it precursors. Existing law also limits the total amount of funds collected by those permit fees, exclusive of district administrative costs, to $3,000,000 in any fiscal year. Existing law requires an annual report to the Governor and the Legislature on the expenditure of those permit fees.~~

~~This bill would authorize the state board to impose additional permit fees directly on nonvehicular sources within a district's jurisdiction. The bill would also authorize the state board to require a district to collect those fees, to establish a system for direct collection of those fees by the state board, and to contract with any other state agency for the collection of those fees. The bill would lower the threshold emission level for the imposition of the permit fees on nonvehicular sources by requiring those fees to be collected from nonvehicular sources that are authorized by the district to emit 250 tons or more per year of any nonattainment pollutant or its precursor. The bill would remove the limit on the total amount of funds that may be collected by the districts in permit fees. The bill would require the annual report to include the expenditure of permit fees imposed as described in (2), below. The additional duties for districts under this bill would impose a state-mandated local program.~~

~~(2) Existing law requires the state board to adopt regulations to achieve the maximum feasible reduction in volatile organic compounds emitted by consumer products, as defined, if the state board determines that the regulations are necessary to attain state and federal air quality standards, and that the regulations are commercially and technologically feasible and necessary.~~

~~This bill would require the state board to impose a fee on any consumer product and any architectural coating sold in the state, if a manufacturer's total sales of consumer products or architectural coatings will result in the emission in the state of 250 tons per year or greater of volatile organic compounds. The bill would require that revenues collected from the imposition of the fee be used to mitigate or reduce air pollution in the state created by consumer products and architectural coatings, as determined by the state board, and that the revenues be expended solely for those purposes.~~

~~(3) Existing law makes a violation of any rule, regulation, permit, or order of the state board or of a district a misdemeanor. By expanding the scope of a crime, this bill would impose a state-mandated local program.~~

~~(4) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement, including the creation of a State Mandates Claims Fund to pay the costs of mandates that do not exceed $1,000,000 statewide and other procedures for claims whose statewide costs exceed $1,000,000.~~

~~This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.~~

~~With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.~~

Vote: ~~majority~~ *2/3*. Appropriation: ~~no~~ *yes*. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 39612 of the Health and Safety Code is~~

SECTION 1. Section 17706 of the Family Code is amended to read:

17706. (a) It is the intent of the Legislature to encourage counties to elevate the visibility and significance of the child support enforcement program in the county. To advance this goal, effective July 1, 2000, the counties with the 10 best performance standards pursuant to clause (ii) of subparagraph (B) of paragraph (2) of subdivision (b) of Section 17704 shall receive an additional 5 percent of the state's share of those counties' collections that are used to reduce or repay aid that is paid pursuant to Article 6 (commencing with Section 11450) of Chapter 2 of Part 3 of Division 9 of the Welfare and Institutions Code. The counties shall use the increased recoupment for child support-related activities that may not be eligible for federal child support funding under Part D of Title IV of the Social Security Act, including, but not limited to, providing services to parents to help them better support their children financially, medically, and emotionally.

(b) The operation of subdivision (a) shall be suspended for the 2002–03 ~~fiscal year~~*, 2003–04, 2004–05, and 2005–06 fiscal years.*

SEC. 2. Section 1266 of the Health and Safety Code is amended to read:

1266. (a) Each new and renewal application for a license for the health facilities listed below shall be accompanied by an annual fee as set forth below.

(1) The annual fee for a general acute care hospital, acute psychiatric hospital, special hospital, and chemical dependency recovery hospital, based on the number of licensed beds, is as follows:

1-49 beds	$460 plus $8 per bed
50-99 beds	$850 plus $8 per bed
100-or more beds	$1,175 plus $8 per bed

(2) The annual fee for a skilled nursing facility, intermediate care facility, and intermediate care facility/developmentally disabled, based on the number of licensed beds, is as follows:

1-59 beds	$2,068 plus $26 per bed
60-99 beds	$2,543 plus $26 per bed
100-or more beds	$3,183 plus $26 per bed

(3) The fees provided in this subdivision shall be adjusted, commencing July 1, 1983, as proposed in the state department's 1983–84 fiscal year Health Facility License Fee Report to the Legislature. Commencing July 1, 1984, fees provided in this subdivision shall be adjusted annually, as directed by the Legislature in the annual Budget Act.

(b) (1) By March 17 of each year, the State Department of Health Services shall make available to interested parties, upon request, information regarding the methodology and calculations used to determine the fee amounts specified in this section, the staffing and systems analysis required under subdivision (e), program costs associated with the licensing provisions of this division, and the actual numerical fee charges to be implemented on ~~June 30~~ *July 1* of that year. ~~The~~ *This information shall specifically identify federal funds received, but not previously budgeted for, the licensing provisions of this division that are used to offset the amount of General Fund money to be recovered through license fees. The information shall also identify the*

purpose of federal funds received for any additional activities under the licensing provisions of this division that are not used to offset the amount of General Fund money.

(2) The methodology and calculations used to determine the fee amounts shall result in fee levels in an amount sufficient to provide revenues equal to the sum of the following:

(A) The General Fund expenditures*, including those attributed to facilities specified in subdivision (c),* for the fiscal year ~~ending on June 30~~ *beginning on July 1* of that year, as specified in the Governor's proposed budget, less license fees estimated to be collected in that fiscal year by the licensing provisions of this division, excluding licensing fees collected pursuant to this section.

(B) The amount of federal funds budgeted for the fiscal year ending June 30 of that year for the licensing provisions of the division, less federal funds received or credited, or anticipated to be received or credited, during that fiscal year for that purpose.

The methodology for calculating the fee levels shall include an adjustment ~~which~~ *that* takes into consideration the actual amount of license fee revenue collected pursuant to this section for that prior fiscal year.

~~(2) The information specified in paragraph (1) shall specifically identify federal funds received, but not previously budgeted for, the licensing provisions of this division that are used to offset the amount of General Fund money to be recovered through license fees. The information shall also identify the purpose of federal funds received for any additional activities under the licensing provisions of this division that are not used to offset the amount of General Fund money.~~

(3) If the Budget Act provides for expenditures that differ by 5 percent from the Governor's proposed budget, the Department of Finance shall adjust the fees to reflect that difference and shall instruct the State Department of Health Services to publish those fees in accordance with subdivision (d).

(c) The annual fees determined pursuant to this section shall be waived for any health facility conducted, maintained, or operated by this state or any state department, authority, bureau, commission, or officer, or by the Regents of the University of California, or by a local hospital district, city, county, or city and county.

(d) The department shall, ~~by July 30 of each year~~ *within 30 calendar days of the enactment of the Budget Act*, publish a list of actual numerical fee charges as adjusted pursuant to this section. This adjustment of fees*, any adjustment by the Department of Finance,* and the publication of the fee list shall not be subject to the *rulemaking* requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. If the published list of fees is higher than that made available to interested parties pursuant to subdivision (b), the affected health facilities may choose to pay the fee in the amount presented at the public hearing and to defer payment of the additional increment until 60 days after publication of the list of fees pursuant to this subdivision.

(e) Prior to the establishment of the annual fee, the ~~state~~ department shall prepare a staffing and systems analysis to ensure efficient and effective utilization of fees collected, proper allocation of departmental resources to licensing and certification activities, survey schedules, complaint investigations, enforcement and appeal activities, data collection and dissemination, surveyor training, and policy development.

The analysis under this subdivision shall be included in the information made available pursuant to subdivision (b), and shall include all of the following:

(1) The number of surveyors and administrative support personnel devoted to the licensing and certification of health care facilities.

(2) The percentage of time devoted to licensing and certification activities for the various types of health facilities.

(3) The number of facilities receiving full surveys and the frequency and number of followup visits.

(4) The number and timeliness of complaint investigations.

(5) Data on deficiencies and citations issued, and numbers of citation review conferences and arbitration hearings.

(6) Training courses provided for surveyors.

(7) Other applicable activities of the licensing and certification division.

The analysis shall also include recommendations for administrative changes to streamline and prioritize the survey process, complaint investigations, management information

systems, word processing capabilities and effectiveness, consumer information system, and surveyor training.

The annual staffing and systems analysis shall be presented to the Health Care Advisory Committee and the Legislature prior to the establishment and adoption of the annual fee.

(f) The annual fee for a congregate living health facility shall initially, and until adjusted by the Legislature in a Budget Act, be based on the number of licensed beds as follows:

1-3 beds	$ 800
4-6 beds	$1,000
7-10 beds	$1,200
11-15 beds	$1,500
16 or more beds	$1,700

Commencing July 1, 1991, fees provided in this subdivision shall be adjusted annually, as directed by the Legislature in the annual budget.

(g) The annual fee for a pediatric day health and respite care facility, as defined in Section 1760.2, shall initially, and until adjusted by the Legislature in a Budget Act, be based on the number of licensed beds as follows:

1-3 beds or clients	$ 800
4-6 beds or clients	$1,000
7-10 beds or clients	$1,200
11-15 beds or clients	$1,500
16 or more beds or clients	$1,700 plus $50 for each additional bed or client over 16 beds or clients

Commencing July 1, 1993, fees provided in this subdivision shall be adjusted annually, as directed by the Legislature in the annual Budget Act.

(h) The department shall, in consultation with affected provider representatives, develop a specific proposal by July 1, 1995, to do all of the following:

(1) Revise the health facility licensure fee methodologies in a manner that addresses the fee methodology and subsidy issues described in the State Auditor Report Number 93020, Issues 2 and 3.

(2) Ensure the validity and reliability of the data systems used to calculate the license fee.

(3) Address the subsidy of licensing and certification activities regarding health facilities for which the annual license fee is waived.

(4) Develop a licensing and certification special fund into which all fees collected by the state department, for health facility licensing, certification, regulation, and inspection duties, functions, and responsibilities, shall be deposited.

SEC. 3. Article 7.5 (commencing with Section 1324) is added to Chapter 2 of Division 2 of the Health and Safety Code, to read:

Article 7.5. Intermediate Care Facilities' Quality Assurance Fees

1324. For purposes of this article, the following definitions apply:

(a) (1) "Gross receipts" means gross receipts paid as compensation for services provided to residents of a designated intermediate care facility.

(2) "Gross receipts" does not mean charitable contributions.

(3) For state and local government owned facilities, "gross receipts" shall include any contributions from government sources or General Fund expenditures for the care of residents of a designated intermediate care facility.

(b) "Eligible facility" means a designated intermediate care facility that has paid the fee as described in Section 1324.2, for a particular state fiscal year.

(c) "Designated intermediate care facility" or "facility" means a facility as defined in subdivision (e), (g), or (h) of Section 1250.

1324.2. (a) As a condition for participation in the Medi-Cal program, there shall be imposed each state fiscal year upon the entire gross receipts of a designated intermediate care facility a quality assurance fee, as calculated in accordance with subdivision (b).

(b) The quality assurance fee to be paid pursuant to subdivision (c) of Section 1324.4 shall be an amount determined each quarter of the state fiscal year by multiplying the facility's gross receipts in the preceding quarter by 6 percent. For reporting purposes, the

quality assurance fee is considered to be on a cash basis of accounting.

1324.4. (a) On or before August 31 of each year, each designated intermediate care facility subject to Section 1324.2 shall report to the department, in a prescribed form, the facility's gross receipts for the preceding state fiscal year.

(b) On or before the last day of each calendar quarter, each designated intermediate care facility shall file a report with the department, in a prescribed form, showing the facility's gross receipts for the preceding quarter.

(c) A newly licensed care facility, as defined by the department, shall be exempt from the requirements of subdivision (a) for its year of operation, but shall complete all requirements of subdivision (b) for any portion of the quarter in which it commences operations.

(d) The quality assurance fee, as calculated pursuant to subdivision (b) of Section 1324.2, shall be paid to the department on or before the last day of the quarter following the quarter for which the fee is imposed.

(e) The payment of the quality assurance fee by a designated intermediate care facility shall be reported as an allowable cost for Medi-Cal reimbursement purposes.

(f) The department shall make retrospective adjustments, as necessary, to the amounts calculated pursuant to subdivision (b) of Section 1324.2 in order to assure that the facility's aggregate quality assurance fee for any particular state fiscal year does not exceed 6 percent of the facility's aggregate annual gross receipts for that year.

1324.6. (a) The Director of Health Services, or his or her designee, shall administer this article.

(b) The director may adopt regulations as are necessary to implement this article. These regulations may be adopted as emergency regulations in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). For purposes of this article, the adoption of regulations shall be deemed an emergency and necessary for the immediate preservation of the public peace, health and safety, or general welfare. The regulations shall include, but not be limited to, any regulations necessary for either of the following purposes:

(1) The administration of this article, including the proper imposition and collection of the quality assurance fee.

(2) The development of any forms necessary to obtain required information from facilities subject to the quality assurance fee.

(c) As an alternative to subdivision (b), and notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement this article by means of a provider bulletin, or other similar instructions, without taking regulatory action.

1324.8. The quality assurance fees assessed and collected pursuant to this article shall be deposited in the General Fund.

1324.10. In addition to the rate of payment that an eligible facility would otherwise receive for intermediate care facility services provided to Medi-Cal beneficiaries, an eligible facility shall receive supplemental Medi-Cal reimbursement, in an amount determined by the department, subject to the following requirements:

(a) The department shall make payments each quarter to an eligible facility in amounts not less than the amounts paid to the department pursuant to subdivision (d) of Section 1324.4 in the preceding quarter. The supplemental Medi-Cal reimbursement provided by this section shall be distributed under a payment methodology based on intermediate care services provided to Medi-Cal patients at the eligible facility, either on a per diem basis, or on any other federally permissible basis.

(b) The department shall make retrospective adjustments as necessary to the amounts paid pursuant to subdivision (a) to assure that the payments made to each eligible facility during a particular state fiscal year are not less than the amounts paid to the department pursuant to subdivision (d) of Section 1324.4.

1324.12. (a) (1) The department shall seek approval from the federal Centers for Medicare and Medicaid Services for the implementation of this article.

(2) If after seeking federal approval, federal approval is not obtained, this article shall not be implemented.

(3) The Director of Health Services may alter the methodology specified in this article to the extent necessary to meet the requirements of federal law or regulations, or to obtain federal approval.

(b) If there is a final judicial determination by any court of appellate jurisdiction or a final determination by the Administrator of the federal Centers for Medicare and Medicaid Services that the supplemental reimbursement provided by this article must be made to any facility not described in this article, this article shall become immediately inoperative.

1324.14. In implementing this article, the department may utilize the services of the Medi-Cal fiscal intermediary through a change order to the fiscal intermediary contract to administer this program, consistent with the requirements of Sections 14104.6, 14104.7, 14104.8, and 14104.9 of the Welfare and Institutions Code.

SEC. 4. Section 1523.1 of the Health and Safety Code is amended to read:

1523.1. (a) (1) A fee adjusted by facility and capacity shall be charged by the department for the issuance of an original license or special permit or for processing any application therefor. After initial licensure, the fee shall be charged by the department annually on each anniversary of the effective date of the license or special permit. The fee is for the purpose of financing a portion of the application and annual processing costs and the activities specified in subdivision (b). The fee shall be assessed as follows:

Fee Schedule

Facility Type	Capacity	Original Application	Annual
Foster Family and Adoption Agencies		~~$1,000~~ *$1,250*	~~$1,000~~ *$1,250*
Other Community Care Facilities, Except Adult Day Programs	1–6	~~$300~~ *$375*	~~$300~~ *$375*
	7–15	~~$450~~ *$563*	~~$450~~ *$563*
	16–49	~~$600~~ *$750*	~~$600~~ *$750*
	50+	~~$750~~ *$938*	~~$750~~ *$938*

Adult Day Programs	1–15	~~$0~~ *$75*	~~$50~~ *$75*
	16–30	~~$100~~ *$125*	~~$100~~ *$125*
	31–60	~~$200~~ *$250*	~~$200~~ *$250*
	61–75	~~$250~~ *$313*	~~$250~~ *$313*
	76–90	~~$300~~ *$375*	~~$300~~ *$375*
	91–120	~~$400~~ *$500*	~~$400~~ *$500*
	121+	~~$500~~ *$625*	~~$500~~ *$625*

(2) ~~Certified family homes of~~ *Subject to paragraph (3),* foster family agencies and foster family homes shall be exempt from the fees imposed pursuant to this subdivision.

(3) No local jurisdiction shall impose any business license, fee, or tax for the privilege of operating a facility licensed under this chapter which serves six or fewer persons.

(b) (1) The revenues collected from licensing fees pursuant to this section shall be utilized by the department to fund increased assistance and monitoring of facilities with a history of noncompliance with licensing laws and regulations pursuant to this chapter, and other administrative activities in support of the licensing program, when appropriated for these purposes. The revenues collected shall be used in addition to any other funds appropriated in the Budget Act in support of the licensing program.

(2) The department shall not utilize any portion of these revenues sooner than 30 days after notification in writing of the purpose and use of this revenue, as approved by the Director of Finance, to the Chairperson of the Joint Legislative Budget Committee, and the chairpersons of the committee in each house that considers appropriations for each fiscal year. For fiscal year 1992–93 and thereafter, the department shall submit a budget change proposal to justify any positions or any other related support costs on an ongoing basis.

(c) A facility may use a bona fide business check to pay the license fee required under this section.

(d) Failure to pay required license fees, including the finding of insufficient funds to cover bona fide business checks submitted for the purpose shall constitute grounds for denial of a license or special permit or forfeiture of a license or special permit.

SEC. 5. Section 1523.2 of the Health and Safety Code is amended to read:

1523.2. (a) Beginning with the 1996–97 fiscal year, there is hereby created in the State Treasury the Technical Assistance Fund, from which money, upon appropriation by the Legislature in the Budget Act, shall be expended by the department to fund the creation and maintenance of new licensing staff positions to provide technical assistance to licensees paying fees pursuant to those sections specified in subdivision (b).

(b) In each fiscal year for fees collected by the department pursuant to Sections 1523.1, 1569.185, and 1596.803, that, in the aggregate, after deducting for administrative costs, total more than six million dollars ($6,000,000), the excess of six million dollars ($6,000,000) shall be expended by the department to fund the creation and maintenance of new licensing staff positions to provide technical assistance to licensees paying fees pursuant to the above specified sections.

(c) Notwithstanding subdivision (b), when revenues in the Technical Assistance Fund reach three million two hundred thirty-seven thousand dollars ($3,237,000), any fees collected over that amount shall remain in the General Fund.

SEC. 6. Section 1568.05 of the Health and Safety Code is amended to read:

1568.05. (a) An annual fee adjusted by capacity shall be charged by the department for a license to operate a residential care facility or for processing any application therefor and, thereafter, shall be charged on each anniversary of the effective date of the license. The fee shall be assessed as follows:

Capacity	Annual Fee
1–6	~~$200 plus $8 per bed~~
	$250 plus $10 per bed
7–15	~~$250 plus $8 per bed~~
	$313 plus $10 per bed
16–25	~~$300 plus $8 per bed~~
	$375 plus $10 per bed
26–50	~~$350 plus $8 per bed~~
	$438 plus $10 per bed

(b) No local governmental entity shall impose any business license, fee, or tax for the privilege of operating a facility licensed under this chapter which serves six or fewer persons.

(c) All fees collected pursuant to subdivision (a) shall be deposited in the Residential Care Facilities for Persons with Chronic, Life-Threatening Illness Fund, which is hereby created in the State Treasury. Moneys in the fund, upon an appropriation made in the annual Budget Act, shall be available to the department for the purposes specified in subdivision (d).

(d) The fund may be used for the purpose of financing a portion of the license application processing costs. In addition, the fund may be utilized by the department to finance postlicensure inspections pursuant to Section 1568.07, to allow increased monitoring of facilities with a history of noncompliance with this chapter and regulations adopted pursuant to this chapter, and other administrative activities in support of the licensing program administered pursuant to this chapter. The revenues collected in the fund shall be used in addition to any other moneys appropriated for the purposes specified in this subdivision.

(e) Fees established pursuant to this section shall not be effective unless licensing fees are established for all adult residential facilities licensed by the department.

(f) A residential care facility may use a bona fide business check to pay the license fee required under this section.

(g) Failure to pay required license fees, including the finding of insufficient funds to cover bona fide business checks submitted for this purpose, may constitute grounds for denial or revocation of a license.

SEC. 7. Section 1569.185 of the Health and Safety Code is amended to read:

1569.185. (a) A fee adjusted by facility and capacity shall be charged by the department for the issuance of an original license to operate a residential care facility for the elderly or for processing any application therefor. After initial licensure, the fee shall be charged by the department annually on each anniversary of the effective date of the license or special permit. The amount of the fee is for the purpose of financing a portion of the application and annual processing costs and the activities specified in subdivision (b). The fee shall be assessed as follows:

Fee Schedule

Capacity	Original Application	Annual
1–6	~~$300~~	~~$300~~
	$375	*$375*
7–15	~~$450~~	~~$450~~
	$563	*$563*
16–49	~~$600~~	~~$600~~
	$750	*$750*
50+	~~$750~~	~~$750~~
	$938	*$938*

No local jurisdiction shall impose any business license, fee, or tax for the privilege of operating a facility licensed under this chapter which serves six or fewer persons.

(b) (1) The revenues collected from licensing fees pursuant to this section when appropriated, shall be utilized by the department, to allow increased assistance and monitoring of facilities with a history of noncompliance with licensing laws and regulations pursuant to this chapter, and other administrative activities in support of the licensing program. The revenues collected shall be used in addition to any other funds appropriated in support of the licensing program.

(2) The department shall not utilize any portion of these revenues sooner than 30 days after notification in writing of the purpose and use, as approved by the Department of Finance, to the Chairperson of the Joint Legislative Budget Committee, and the chairpersons of the committee in each house that considers appropriations for each fiscal year. For fiscal year 1992–93 and thereafter, the department shall submit a budget change proposal

to justify any positions or any other related support costs on an ongoing basis.

(c) A residential care facility for the elderly may use a bona fide business check to pay the license fee required under this section.

(d) Failure to pay required license fees, including the finding of insufficient funds to cover bona fide business checks submitted for this purpose, shall constitute grounds for denial of a license or special permit or forfeiture of a license or special permit.

SEC. 8. Section 1596.803 of the Health and Safety Code is amended to read:

1596.803. (a) (1) A fee adjusted by facility and capacity shall be charged by the department for the issuance of an original license to operate a child day care facility or for processing any application therefor. After initial licensure, the fee shall be charged by the department annually. The amount of the fee is for the purpose of financing a portion of the application and annual processing costs and the activities specified in subdivision (b). The fee shall be assessed as follows:

Fee Schedule

Facility Type	Capacity	Original Application	Annual Fee
Family Day Care	~~1–6~~	~~$25~~	~~$25~~
	1–8	*$50*	*$50*
	~~7–12~~	~~$50~~	~~$50~~
	9–14	*$100*	*$100*
Day Care Centers	1–30	~~$100~~	~~$100~~
		$200	*$200*
	31–60	~~$200~~	~~$200~~
		$400	*$400*
	61–75	~~$250~~	~~$250~~
		$500	*$500*
	76–90	~~$300~~	~~$300~~
		$600	*$600*
	91–120	~~$400~~	~~$400~~
		$800	*$800*
	121+	~~$500~~	~~$500~~
		$1,000	*$1,000*

(2) ~~(A) Notwithstanding paragraph (1), any licensee, including, but not limited to, public agencies with more than one licensed facility shall pay no more than five hundred dollars ($500) for the original application and five hundred dollars ($500) for the annual fee if the capacity is less than 1,000 children in the aggregate. Any licensee, including, but not limited to, public agencies with more than one licensed facility shall pay no more than one thousand dollars ($1,000) for the original application and one thousand dollars ($1,000) for the annual fee if the capacity is 1,000 children or more in the aggregate.~~

~~(B) Notwithstanding subparagraph (A), the fees provided for in paragraph (1) shall also apply to any for-profit corporation, person, firm, association, or partnership holding 25 or more day care center licenses.~~

~~(3)~~ No local jurisdiction shall impose any business license, fee, or tax for the privilege of operating a small family day care home licensed under this act.

(b) (1) The revenues collected from licensing fees pursuant to this section, when appropriated, shall be utilized by the department to allow increased assistance and monitoring of facilities with a history of noncompliance with licensing laws and regulations pursuant to this act, and other administrative activities in support of the licensing program. The revenues collected shall be used in addition to any other funds appropriated in support of the licensing program.

(2) The department shall not utilize any portion of these revenues sooner than 30 days after notification in writing of the purpose and use, as approved by the Department of Finance, to the Chairperson of the Joint Legislative Budget Committee, and the chairpersons of the committee in each house that considers appropriations for each fiscal year. For fiscal year 1992–93 and thereafter, the department shall submit a budget change proposal to justify any positions or any other related support costs on an ongoing basis.

(c) A child day care facility may use a bona fide business or personal check to pay the license fee required under this section.

(d) Failure to pay required license fees, including the finding of insufficient funds to cover bona fide business or personal checks submitted for this purpose, shall constitute grounds for denial of

a license or special permit or forfeiture of a license or special permit.

(e) The department shall assess the fees on an annual basis and may set time periods to spread the licensee's due dates throughout the year. The fees shall be considered delinquent 30 days after the billing date.

SEC. 9. Section 104181.5 of the Health and Safety Code is repealed.

~~104181.5. The department, in awarding grants under this program, shall not encumber money allocated in any fiscal year other than the fiscal year in which the appropriation was made beginning with nonobligated 2000–01 fiscal year funds, subject to receiving multiyear spending authority for those funds.~~

SEC. 10. Section 104181.5 is added to the Health and Safety Code, to read:

104181.5. Notwithstanding subdivision (a) of Section 2.00 of the Budget Act of 2002 and any other provision of law, commencing with the appropriation for the 2002–03 fiscal year, and for each fiscal year thereafter, any amount appropriated to the department for the Cancer Research Program shall be available, for purposes of that program, for encumbrance for one fiscal year beyond the year of appropriation and for expenditure for three fiscal years beyond the year of encumbrance.

SEC. 11. Section 104322 of the Health and Safety Code is amended to read:

104322. (a) The State Department of Health Services shall develop, expand, and ensure quality prostate cancer treatment to low-income and uninsured men. The department shall award one or more contracts to provide prostate cancer treatment through private or public nonprofit organizations, including, but not limited to, community-based organizations, local health care providers, and the University of California medical centers. The contracts shall not be subject to Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(b) Treatment provided under this chapter shall be provided to uninsured and underinsured men with incomes at or below 200 percent of the federal poverty level.

(c) The department shall contract for prostate cancer treatment services only at the level of funding budgeted from state and other

sources during a fiscal year in which the Legislature has appropriated funds to the department for this purpose.

(d) Notwithstanding subdivision (a) of Section 2.00 of the Budget Act of 2003 and any other provision of law, commencing with the 2003–04 fiscal year and for each fiscal year thereafter, any amount appropriated to the department for the prostate cancer treatment program implemented pursuant to this chapter shall be made available, for purposes of that program, for encumbrance for one fiscal year beyond the year of appropriation and for expenditure for two fiscal years beyond the year of encumbrance.

SEC. 12. Section 127880 of the Health and Safety Code is amended to read:

127880. It is the intent of the Legislature*, subject to available funds,* to maintain a Health Professions Career Opportunity Program designed to *do both of the following*:

(a) Increase the number of ethnic minorities in health professional training.

(b) Increase the number of minority health professionals practicing in health manpower shortage areas in this area.

SEC. 13. Section 127885 of the Health and Safety Code is amended to read:

127885. The office shall maintain*, contingent upon an appropriation in the annual Budget Act or other statute,* a Health Professions Career Opportunity Program that shall include, but not be limited to, all of the following:

(a) Producing and disseminating a series of publications aimed at informing and motivating minority and disadvantaged students to pursue health professional careers.

(b) Conducting a conference series aimed at informing those students of opportunities in health professional training and mechanisms of successfully preparing to enter the training.

(c) Providing support and technical assistance to health professional schools and colleges as well as student and community organizations active in minority health professional development.

(d) Conducting relevant manpower information and data analysis in the field of minority and disadvantaged health professional development.

(e) Providing necessary consultation, recruitment, and counseling through other means.

(f) Supporting and encouraging minority health professionals in training to practice in health professional shortage areas of California.

SEC. 14. Section 4785 is added to the Welfare and Institutions Code, to read:

4785. (a) The department shall establish and administer a copayment program, pursuant to this section, for services purchased through a regional center.

(b) Subject to subdivision (c), the parent or parents of a child who is aged 3 to 17 years, inclusive, who resides in the parent's or parents' home and who receives services purchased through a regional center, shall pay a copayment for the services provided to the child.

(c) No copayment may be assessed against the parent or parents if the total of the parent's or parents' adjusted gross income, as defined for purposes of state income tax during the year in which the services are provided, is less than 200 percent of the federal poverty level guidelines.

(d) The department shall determine the amount of the copayment. The copayment imposed for each child during one year may not exceed the actual cost of the services being provided. In determining the copayment amount, the department shall institute a sliding fee scale, taking into account the parent or parents' ability to pay, based on their adjusted gross income. The department shall also adjust the copayment for family size and for the parent or parents of more than one child subject to the copayment, as provided in subdivision (b).

(e) The department shall impose all copayments based on service utilization.

(f) The department shall collect all of the payments pursuant to this section and may take action, as necessary, to effect that collection, within or without the state. All copayments collected pursuant to this section shall be remitted to the State Treasury and deposited into the General Fund.

(g) The department may adopt regulations to implement this section. If the department adopts regulations, the adoption of these regulations shall be deemed necessary for the immediate preservation of the public peace, health and safety, or general welfare for purposes of subdivision (b) of Section 113461 of the Government Code.

SEC. 15. Chapter 13 (commencing with Section 4850) is added to Division 4.5 of the Welfare and Institutions Code, to read:

CHAPTER 13. HABILITATION SERVICES FOR THE DEVELOPMENTALLY DISABLED

4850. On and after July 1, 2003, the State Department of Developmental Services shall succeed to all functions and responsibilities of the Department of Rehabilitation with respect to the administration of the Habilitation Services Program established pursuant to former Chapter 4.5 (commencing with Section 19350) of Part 2 of Division 10.

SEC. 16. Section 11453 of the Welfare and Institutions Code is amended to read:

11453. (a) Except as provided in subdivision (c), the amounts set forth in Section 11452 and subdivision (a) of Section 11450 shall be adjusted annually by the department to reflect any increases or decreases in the cost of living. These adjustments shall become effective July 1 of each year, unless otherwise specified by the Legislature. For the 2000–01 fiscal year to the 2003–04 fiscal year, inclusive, these adjustments shall become effective October 1 of each year. The cost-of-living adjustment shall be calculated by the Department of Finance based on the changes in the California Necessities Index, which as used in this section means the weighted average changes for food, clothing, fuel, utilities, rent, and transportation for low-income consumers. The computation of annual adjustments in the California Necessities Index shall be made in accordance with the following steps:

(1) The base period expenditure amounts for each expenditure category within the California Necessities Index used to compute the annual grant adjustment are:

Food	$ 3,027
Clothing (apparel and upkeep)	406
Fuel and other utilities	529
Rent, residential	4,883
Transportation	1,757
Total	$10,602

(2) Based on the appropriate components of the Consumer Price Index for All Urban Consumers, as published by the United States Department of Labor, Bureau of Labor Statistics, the percentage change shall be determined for the 12-month period ending with the December preceding the year for which the cost-of-living adjustment will take effect, for each expenditure category specified in subdivision (a) within the following geographical areas: Los Angeles-Long Beach-Anaheim, San Francisco-Oakland, San Diego, and, to the extent statistically valid information is available from the Bureau of Labor Statistics, additional geographical areas within the state which include not less than 80 percent of recipients of aid under this chapter.

(3) Calculate a weighted percentage change for each of the expenditure categories specified in subdivision (a) using the applicable weighting factors for each area used by the State Department of Industrial Relations to calculate the California Consumer Price Index (CCPI).

(4) Calculate a category adjustment factor for each expenditure category in subdivision (a) by (1) adding 100 to the applicable weighted percentage change as determined in paragraph (2) and (2) dividing the sum by 100.

(5) Determine the expenditure amounts for the current year by multiplying each expenditure amount determined for the prior year by the applicable category adjustment factor determined in paragraph (4).

(6) Determine the overall adjustment factor by dividing (1) the sum of the expenditure amounts as determined in paragraph (4) for the current year by (2) the sum of the expenditure amounts as determined in subdivision (d) for the prior year.

(b) The overall adjustment factor determined by the preceding computation steps shall be multiplied by the schedules established pursuant to Section 11452 and subdivision (a) of Section 11450 as are in effect during the month of June preceding the fiscal year in which the adjustments are to occur and the product rounded to the nearest dollar. The resultant amounts shall constitute the new schedules ~~which~~ *that* shall be filed with the Secretary of State.

(c) (1) No adjustment to the maximum aid payment set forth in subdivision (a) of Section 11450 shall be made under this section for the purpose of increasing the benefits under this chapter for the 1990–91, 1991–92, 1992–93, 1993–94, 1994–95,

1995–96, 1996–97, and 1997–98 fiscal years, and through October 31, 1998, to reflect any change in the cost of living. For the 1998–99 fiscal year, the cost-of-living adjustment that would have been provided on July 1, 1998, pursuant to subdivision (a) shall be made on November 1, 1998. Elimination of the cost-of-living adjustment pursuant to this paragraph shall satisfy the requirements of Section 11453.05, and no further reduction shall be made pursuant to that section.

(2) No adjustment to the minimum basic standard of adequate care set forth in Section 11452 shall be made under this section for the purpose of increasing the benefits under this chapter for the 1990–91 and 1991–92 fiscal years to reflect any change in the cost of living.

(3) In any fiscal year commencing with the 2000–01 fiscal year to the 2003–04 fiscal year, inclusive, when there is any increase in tax relief pursuant to the applicable paragraph of subdivision (a) of Section 10754 of the Revenue and Taxation Code, then the increase pursuant to subdivision (a) of this section shall occur. In any fiscal year commencing with the 2000–01 fiscal year to the 2003–04 fiscal year, inclusive, when there is no increase in tax relief pursuant to the applicable paragraph of subdivision (a) of Section 10754 of the Revenue and Taxation Code, then any increase pursuant to subdivision (a) of this section shall be suspended.

(4) Notwithstanding paragraph (3), ~~an~~ *no* adjustment to the maximum aid payments set forth in subdivision (a) of Section 11450 shall be made under this section for the 2002–03 *and 2003–04* fiscal ~~year, but the adjustment shall become effective June 1, 2003~~ *years.*

(d) Adjustments for subsequent fiscal years pursuant to this section shall not include any adjustments for any fiscal year in which the cost of living was suspended pursuant to subdivision (c).

SEC. 17. Section 11462 of the Welfare and Institutions Code is amended to read:

11462. (a) (1) Effective July 1, 1990, foster care providers licensed as group homes, as defined in departmental regulations, including public child care institutions, as defined in Section 11402.5, shall have rates established by classifying each group home program and applying the standardized schedule of rates. The department shall collect information from group providers

beginning January 1, 1990, in order to classify each group home program.

(2) Notwithstanding paragraph (1), foster care providers licensed as group homes shall have rates established only if the group home is organized and operated on a nonprofit basis as required under subdivision (h) of Section 11400. The department shall terminate the rate effective January 1, 1993, of any group home not organized and operated on a nonprofit basis as required under subdivision (h) of Section 11400.

(3) The department shall determine, consistent with the requirements of this chapter and other relevant requirements under law, the rate classification level (RCL) for each group home program on a biennial basis. Submission of the biennial rate application shall be made according to a schedule determined by the department. The department shall implement this paragraph through the adoption of emergency regulations.

(b) A group home program shall be initially classified, for purposes of emergency regulations, according to the level of care and services to be provided using a point system developed by the department and described in the report, ''The Classification of Group Home Programs under the Standardized Schedule of Rates System,'' prepared by the State Department of Social Services, August 30, 1989.

(c) The rate for each ~~rate classification level (RCL)~~ *RCL* has been determined by the department with data from the AFDC-FC Group Home Rate Classification Pilot Study. The rates effective July 1, 1990, were developed using 1985 calendar year costs and reflect adjustments to the costs for each fiscal year, starting with the 1986–87 fiscal year, by the amount of the California Necessities Index computed pursuant to the methodology described in Section 11453. The data obtained by the department using 1985 calendar year costs shall be updated and revised by January 1, 1993.

(d) As used in this section, ''standardized schedule of rates'' means a listing of the 14 rate classification levels, and the single rate established for each RCL.

(e) Except as specified in paragraph (1), the department shall determine the RCL for each group home program on a prospective basis, according to the level of care and services that the group

home operator projects will be provided during the period of time for which the rate is being established.

(1) (A) For new and existing providers requesting the establishment of an RCL, and for existing group home programs requesting an RCL increase, the department shall determine the RCL no later than 13 months after the effective date of the provisional rate. The determination of the RCL shall be based on a program audit of documentation and other information that verifies the level of care and supervision provided by the group home program during a period of the two full calendar months or 60 consecutive days, whichever is longer, preceding the date of the program audit, unless the group home program requests a lower RCL. The program audit shall not cover the first six months of operation under the provisional rate. Pending the department's issuance of the program audit report that determines the RCL for the group home program, the group home program shall be eligible to receive a provisional rate that shall be based on the level of care and service that the group home program proposes it will provide. The group home program shall be eligible to receive only the RCL determined by the department during the pendency of any appeal of the department's RCL determination.

(B) A group home program may apply for an increase in its RCL no earlier than two years from the date the department has determined the group home program's rate, unless the host county, the primary placing county, or a regional consortium of counties submits to the department in writing that the program is needed in that county, that the provider is capable of effectively and efficiently operating the proposed program, and that the provider is willing and able to accept AFDC-FC children for placement who are determined by the placing agency to need the level of care and services that will be provided by the program.

(C) To ensure efficient administration of the department's audit responsibilities, and to avoid the fraudulent creation of records, group home programs shall make records that are relevant to the RCL determination available to the department in a timely manner. Except as provided in this section, the department may refuse to consider, for purposes of determining the rate, any documents that are relevant to the determination of the RCL that are not made available by the group home provider by the date the group home provider requests a hearing on the department's RCL

determination. The department may refuse to consider for purposes of determining the rate, the following records, unless the group home provider makes the records available to the department during the field work portion of the department's program audit:

(i) Records of each employee's full name, home address, occupation, and social security number.

(ii) Time records showing when the employee begins and ends each work period, meal periods, split shift intervals, and total daily hours worked.

(iii) Total wages paid each payroll period.

(iv) Records required to be maintained by licensed group home providers under the provisions of Title 22 of the California Code of Regulations that are relevant to the RCL determination.

(D) To minimize financial abuse in the startup of group home programs, when the department's RCL determination is more than three levels lower than the RCL level proposed by the group home provider, and the group home provider does not appeal the department's RCL determination, the department shall terminate the rate of a group home program 45 days after issuance of its program audit report. When the group home provider requests a hearing on the department's RCL determination, and the RCL determined by the director under subparagraph (E) is more than three levels lower than the RCL level proposed by the group home provider, the department shall terminate the rate of a group home program within 30 days of issuance of the director's decision. Notwithstanding the reapplication provisions in subparagraph (B), the department shall deny any request for a new or increased RCL from a group home provider whose RCL is terminated pursuant to this subparagraph, for a period of no greater than two years from the effective date of the RCL termination.

(E) A group home provider may request a hearing of the department's RCL determination under subparagraph (A) no later than 30 days after the date the department issues its RCL determination. The department's RCL determination shall be final if the group home provider does not request a hearing within the prescribed time. Within 60 days of receipt of the request for hearing, the department shall conduct a hearing on the RCL determination. The standard of proof shall be the preponderance of the evidence and the burden of proof shall be on the department.

The hearing officer shall issue the proposed decision within 45 days of the close of the evidentiary record. The director shall adopt, reject, or modify the proposed decision, or refer the matter back to the hearing officer for additional evidence or findings within 100 days of issuance of the proposed decision. If the director takes no action on the proposed decision within the prescribed time, the proposed decision shall take effect by operation of law.

(2) Group home programs that fail to maintain at least the level of care and services associated with the RCL upon which their rate was established shall inform the department. The department shall develop regulations specifying procedures to be applied when a group home fails to maintain the level of services projected, including, but not limited to, rate reduction and recovery of overpayments.

(3) The department shall not reduce the rate, establish an overpayment, or take other actions pursuant to paragraph (2) for any period that a group home program maintains the level of care and services associated with the RCL for children actually residing in the facility. Determinations of levels of care and services shall be made in the same way as modifications of overpayments are made pursuant to paragraph (2) of subdivision (b) of Section 11466.2.

(4) A group home program that substantially changes its staffing pattern from that reported in the group home program statement shall provide notification of this change to all counties that have placed children currently in care. This notification shall be provided whether or not the RCL for the program may change as a result of the change in staffing pattern.

(f) (1) The standardized schedule of rates for fiscal year 2002–03 is:

Rate Classification Level	Point Ranges	FY 2002–03 Standard Rate
1	Under 60	$1,454
2	60–89	1,835
3	90–119	2,210
4	120–149	2,589
5	150–179	2,966

6	180–209	3,344
7	210–239	3,723
8	240–269	4,102
9	270–299	4,479
10	300–329	4,858
11	330–359	5,234
12	360–389	5,613
13	390–419	5,994
14	420 & Up	6,371

(2) (A) For group home programs that receive AFDC-FC payments for services performed during the 2002–03 fiscal year, the adjusted RCL point ranges below shall be used in performing program audits and in determining any resulting rate reduction, overpayment assessment, or other actions pursuant to paragraph (2) of subdivision (e):

Rate Classification Level	Adjusted Point Ranges for 2002–03
1	Under 54
2	54–81
3	82–110
4	111–138
5	139–167
6	168–195
7	196–224
8	225–253
9	254–281
10	282–310
11	311–338
12	339–367
13	368–395
14	396 & Up

(B) Notwithstanding subparagraph (A), foster care providers operating group homes during the 2002–03 fiscal year shall remain responsible for ensuring the health and safety of the children placed in their programs in accordance with existing applicable provisions of the Health and Safety Code and

community care licensing regulations, as contained in Title 22 of the Code of California Regulations.

(C) Subparagraph (A) shall not apply to program audits of group home programs with provisional rates established pursuant to paragraph (1) of subdivision (e). For those program audits, the RCL point ranges in paragraph (1) shall be used.

(g) (1) (A) For the 1999–2000 fiscal year, the standardized rate for each RCL shall be adjusted by an amount equal to the California Necessities Index computed pursuant to the methodology described in Section 11453. The resultant amounts shall constitute the new standardized schedule of rates, subject to further adjustment pursuant to subparagraph (B).

(B) In addition to the adjustment in subparagraph (A), commencing January 1, 2000, the standardized rate for each RCL shall be increased by 2.36 percent, rounded to the nearest dollar. The resultant amounts shall constitute the new standardized schedule of rates.

(2) Beginning with the 2000–01 fiscal year, the standardized schedule of rates shall be adjusted annually by an amount equal to the CNI computed pursuant to Section 11453, subject to the availability of funds. The resultant amounts shall constitute the new standardized schedule of rates.

(3) Effective January 1, 2001, the amount included in the standard rate for each Rate Classification Level for the salaries, wages, and benefits for staff providing child care and supervision or performing social work activities, or both, shall be increased by 10 percent. This additional funding shall be used by group home programs solely to supplement staffing, salaries, wages, and benefit levels of staff specified in this paragraph. The standard rate for each RCL shall be recomputed using this adjusted amount and the resultant rates shall constitute the new standardized schedule of rates. The department may require a group home receiving this additional funding to certify that the funding was utilized in accordance with the provisions of this section.

(h) The standardized schedule of rates pursuant to subdivisions (f) and (g) shall be implemented as follows:

(1) Any group home program which received an AFDC-FC rate in the prior fiscal year at or above the standard rate for the RCL in the current fiscal year shall continue to receive that rate.

(2) Any group home program which received an AFDC-FC rate in the prior fiscal year below the standard rate for the RCL in the current fiscal year shall receive the RCL rate for the current year.

(i) (1) The department shall not establish a rate for a new program of a new or existing provider unless the provider submits a recommendation from the host county, the primary placing county, or a regional consortium of counties that the program is needed in that county; that the provider is capable of effectively and efficiently operating the program; and that the provider is willing and able to accept AFDC-FC children for placement who are determined by the placing agency to need the level of care and services that will be provided by the program.

(2) The department shall encourage the establishment of consortia of county placing agencies on a regional basis for the purpose of making decisions and recommendations about the need for, and use of, group home programs and other foster care providers within the regions.

(3) The department shall annually conduct a county-by-county survey to determine the unmet placement needs of children placed pursuant to Section 300 and Section 601 or 602, and shall publish its findings by November 1 of each year.

(j) The department shall develop regulations specifying ratesetting procedures for program expansions, reductions, or modifications, including increases or decreases in licensed capacity, or increases or decreases in level of care or services.

(k) (1) For the purpose of this subdivision, ''program change'' means any alteration to an existing group home program planned by a provider that will increase the RCL or AFDC-FC rate. An increase in the licensed capacity or other alteration to an existing group home program that does not increase the RCL or AFDC-FC rate shall not constitute a program change.

(2) For the 1998–99, 1999–2000, and 2000–01 fiscal years, the rate for a group home program shall not increase, as the result of a program change, from the rate established for the program effective July 1, 2000, and as adjusted pursuant to subparagraph (B) of paragraph (1) of subdivision (g), except as provided in paragraph (3).

(3) (A) For the 1998–99, 1999–2000, and 2000–01 fiscal years, the department shall not establish a rate for a new program

of a new or existing provider or approve a program change for an existing provider that either increases the program's RCL or AFDC-FC rate, or increases the licensed capacity of the program as a result of decreases in another program with a lower RCL or lower AFDC-FC rate that is operated by that provider, unless both of the conditions specified in this paragraph are met.

(i) The licensee obtains a letter of recommendation from the host county, primary placing county, or regional consortium of counties regarding the proposed program change or new program.

(ii) The county determines that there is no increased cost to the General Fund.

(B) Notwithstanding subparagraph (A), the department may grant a request for a new program or program change, not to exceed 25 beds, statewide, if (i) the licensee obtains a letter of recommendation from the host county, primary placing county, or regional consortium of counties regarding the proposed program change or new program, and (ii) the new program or program change will result in a reduction of referrals to state hospitals during the 1998–99 fiscal year.

(*l*) General unrestricted or undesignated private charitable donations and contributions made to charitable or nonprofit organizations shall not be deducted from the cost of providing services pursuant to this section. The donations and contributions shall not be considered in any determination of maximum expenditures made by the department.

(m) The department shall, by October 1 each year, commencing October 1, 1992, provide the Joint Legislative Budget Committee with a list of any new departmental requirements established during the previous fiscal year concerning the operation of group homes, and of any unusual, industrywide increase in costs associated with the provision of group care which may have significant fiscal impact on providers of group homes care. The committee may, in fiscal year 1993–94 and beyond, use the list to determine whether an appropriation for rate adjustments is needed in the subsequent fiscal year.

SEC. 18. Section 11462.06 of the Welfare and Institutions Code is amended to read:

11462.06. (a) For purposes of the administration of this article, including the setting of group home rates, the department shall deem the reasonable costs of leases for shelter care for foster

children to be allowable costs. Reimbursement of shelter costs shall not exceed 12 percent of the fair market value of owned, leased, or rented buildings, including any structures, improvements, edifices, land, grounds, and other similar property that is owned, leased, or rented by the group home and that is used for group home programs and activities, exclusive of idle capacity and capacity used for nongroup home programs and activities. Shelter costs shall be considered reasonable in relation to the fair market value limit as described in subdivision ~~(c)~~ *(b)*. ~~Allowable costs of affiliated leases (1) shall be subject to a review by the Charitable Trust Section of the Department of Justice as specified by Chapter 15 (commencing with Section 999) of Division 1 of Title 11 of the California Code of Regulations and (2) shall be permitted to the extent allowed by federal law for federal financial participation.~~

(b) ~~Effective July 1, 1998, an approval letter from the Charitable Trust Section of the Department of Justice shall be required for approval of shelter costs that result from self-dealing transactions, as defined in Section 5233 of the Corporations Code.~~

~~(c)~~ For purposes of this section, fair market value of leased property shall be determined by either of the following methods, as chosen by the provider:

(1) The market value shown on the last tax bill for the cost reporting period.

(2) The market value determined by an independent appraisal. The appraisal shall be performed by a qualified, professional appraiser who, at a minimum, meets standards for appraisers as specified in Chapter 6.5 (commencing with Section 3500) of Title 10 of the California Code of Regulations. The appraisal shall not be deemed independent if performed under a less-than-arms-length agreement, or if performed by a person or persons employed by, or under contract with, the group home for purposes other than performing appraisals, or by a person having a material interest in any group home which receives foster care payments. If the department believes an appraisal does not meet these standards, the department shall give its reasons in writing to the provider and provide an opportunity for appeal.

~~(d)~~

(c) (1) The department may adopt emergency regulations in order to implement this section, in accordance with Chapter 3.5

(commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) The adoption of emergency regulations pursuant to this section shall be deemed to be an emergency and considered by the Office of Administrative Law as necessary for the immediate preservation of the public peace, health and safety, or general welfare.

(3) Emergency regulations adopted pursuant to this section shall be exempt from the review and approval of the Office of Administrative Law.

(4) The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and publication in the California Code of Regulations.

SEC. 19. Section 11463 of the Welfare and Institutions Code is amended to read:

11463. (a) The department, with the advice, assistance, and cooperation of the counties and foster care providers, shall develop, implement, and maintain a ratesetting system for foster family agencies.

No county shall be reimbursed for any percentage increases in payments, made on behalf of AFDC-FC funded children who are placed with foster family agencies, ~~which~~ *that* exceed the percentage cost-of-living increase provided in any fiscal year beginning on January 1, 1990, as specified in subdivision (c) of Section 11461.

(b) The department shall develop regulations specifying the purposes, types, and services of foster family agencies, including the use of those agencies for the provision of emergency shelter care. Distinction for ratesetting purposes shall be drawn between foster family agencies which provide treatment of children in foster families and those ~~which~~ *that* provide nontreatment services.

(c) The department shall develop and maintain regulations specifying the procedure for the appeal of department decisions about the setting of an agency's rate.

(d) On and after July 1, 1998, the schedule of rates, and the components used in the rate calculations specified in the department's regulations, for foster family agencies shall be increased by 6 percent, rounded to the nearest dollar. The resultant

amounts shall constitute the new schedule of rates for foster family agencies.

(e) (1) On and after July 1, 1999, the schedule of rates and the components used in the rate calculations specified in the department's regulations for foster family agencies shall be adjusted by an amount equal to the California Necessities Index computed pursuant to Section 11453, rounded to the nearest dollar, subject to the availability of funds. The resultant amounts shall constitute the new schedule of rates for foster family agencies, subject to further adjustment pursuant to paragraph (2).

(2) In addition to the adjustment specified in paragraph (1), commencing January 1, 2000, the schedule of rates and the components used in the rate calculations specified in the department's regulations for foster family agencies shall be increased by 2.36 percent, rounded to the nearest dollar. The resultant amounts shall constitute the new schedule of rates for foster family agencies.

(f) For the 1999–2000 fiscal year, foster family agency rates that are not determined by the schedule of rates set forth in the department's regulations, shall be increased by the same percentage as provided in subdivision (e).

(g) For the 2000–01 fiscal year and each fiscal year thereafter, without a county share of cost, notwithstanding subdivision (c) of Section 15200, the foster family agency rate shall be supplemented by one hundred dollars ($100) for clothing per year per child in care, subject to the availability of funds. The supplemental payment shall be used to supplement, and shall not be used to supplant, any clothing allowance paid in addition to the foster family agency rate.

(h) In addition to the adjustment made pursuant to subdivision (e), the component for social work activities in the rate calculation specified in the department's regulations for foster family agencies shall be increased by 10 percent, effective January 1, 2001. This additional funding shall be used by foster family agencies solely to supplement staffing, salaries, wages, and benefit levels of staff performing social work activities. The schedule of rates shall be recomputed using the adjusted amount for social work activities. The resultant amounts shall constitute the new schedule of rates for foster family agencies. The department may require a foster family

agency receiving this additional funding to certify that the funding was utilized in accordance with the provisions of this section.

(i) The department shall determine, consistent with the requirements of this section and other relevant requirements under law, the rate category for each foster family agency on a biennial basis. Submission of the biennial rate application shall be according to a schedule determined by the department. The department shall implement this subdivision through the adoption of emergency regulations.

SEC. 20. Section 11466.2 of the Welfare and Institutions Code is amended to read:

11466.2. (a) The department shall perform or have performed group home program and fiscal audits as needed. *An audit period may be less than the period for which the rate is established.* Group home programs shall maintain all child-specific, programmatic, personnel, fiscal, and other information affecting group home ratesetting and AFDC-FC payments for a period not less than five years.

(b) (1) The department shall develop regulations to correct a group home program's RCL, and to adjust the rate and to recover any overpayments resulting from an overstatement of the projected level of care and services.

(2) Beginning in fiscal year 1990–91, the department shall modify the amount of the overpayment pursuant to paragraph (1) in cases where the level of care and services provided per child in placement equals or exceeds the level associated with the program's RCL. In making this modification, the department shall determine whether services other than child care supervision were provided to children in placement in an amount that is at least proportionate on a per child basis to the amount projected in the group home's rate application. In cases where these services are provided in less than a proportionate amount, staffing for child care supervision in excess of its proportionate share shall not be substituted for ~~non-child~~ *nonchild* care supervision staff hours.

(c) (1) In any audit conducted by the department, the department, or other public or private audit agency with which the department contracts, shall coordinate with the department's licensing and ratesetting entities so that a consistent set of standards, rules, and auditing protocols are maintained. The department, or other public or private audit agency with which the

department contracts, shall make available to all group home providers, in writing, any standards, rules, and auditing protocols to be used in those audits.

(2) The department shall provide exit interviews with providers whenever deficiencies found are explained and the opportunity exists for providers to respond. The department shall ~~develop~~ *adopt* regulations specifying the procedure for the appeal of audit findings.

SEC. 21. Section 11466.35 of the Welfare and Institutions Code is amended to read:

11466.35. (a) Any licensee who has been determined to owe a sustained overpayment under this chapter, and who, subsequent to notice of the sustained overpayment, has its group home rate terminated, shall be ineligible to apply or receive a rate for any future group home program until the overpayment is repaid.

(b) ~~An annual~~ *A* rate application shall be denied for a group home provider that meets either of the following conditions:

(1) A provider owing a sustained overpayment under this chapter, upon the occurrence of any additional sustained overpayment, shall be ineligible to apply or receive a rate for an existing or future group home program until the sustained overpayments are repaid, unless a voluntary repayment agreement is approved by the department.

(2) A provider incurring a sustained overpayment that constitutes more than 60 percent of the provider's annual rate reimbursement shall be ineligible to apply or receive a rate for any existing or future group home programs until the sustained overpayments are repaid, unless a voluntary repayment agreement is approved by the department.

SEC. 22. Section 12201 of the Welfare and Institutions Code is amended to read:

12201. (a) Except as provided in subdivision (d), the payment schedules set forth in Section 12200 shall be adjusted annually to reflect any increases or decreases in the cost of living. ~~Except as provided in subdivision (e), these~~ *These* adjustments shall become effective January 1 of each year. The cost-of-living adjustment shall be based on the changes in the California Necessities Index, which as used in this section shall be the weighted average of changes for food, clothing, fuel, utilities, rent, and transportation for low-income consumers. The computation

of annual adjustments in the California Necessities Index shall be made in accordance with the following steps:

(1) The base period expenditure amounts for each expenditure category within the California Necessities Index used to compute the annual grant adjustment are:

Food	$ 3,027
Clothing (apparel and upkeep)	406
Fuel and other utilities	529
Rent, residential	4,883
Transportation	1,757
Total	$10,602

(2) Based on the appropriate components of the Consumer Price Index for All Urban Consumers, as published by the United States Department of Labor, Bureau of Labor Statistics, the percentage change shall be determined for the 12-month period which ends 12 months prior to the January in which the cost-of-living adjustment will take effect, for each expenditure category specified in paragraph (1) within the following geographical areas: Los Angeles-Long Beach-Anaheim, San Francisco-Oakland, San Diego, and, to the extent statistically valid information is available from the Bureau of Labor Statistics, additional geographical areas within the state which include not less than 80 percent of recipients of aid under this chapter.

(3) Calculate a weighted percentage change for each of the expenditure categories specified in subdivision (a) using the applicable weighting factors for each area used by the State Department of Industrial Relations to calculate the California Consumer Price Index (CCPI).

(4) Calculate a category adjustment factor for each expenditure category in paragraph (1) by (1) adding 100 to the applicable weighted percentage change as determined in paragraph (2) and (2) dividing the sum by 100.

(5) Determine the expenditure amounts for the current year by multiplying each expenditure amount determined for the prior year by the applicable category adjustment factor determined in paragraph (4).

(6) Determine the overall adjustment factor by dividing (1) the sum of the expenditure amounts as determined in paragraph (4) for the current year by (2) the sum of the expenditure amounts as determined in paragraph (4) for the prior year.

(b) The overall adjustment factor determined by the preceding computational steps shall be multiplied by the payment schedules established pursuant to Section 12200 as are in effect during the month of December preceding the calendar year in which the adjustments are to occur, and the product rounded to the nearest dollar. The resultant amounts shall constitute the new schedules for the categories given under subdivisions (a), (b), (c), (d), (e), (f), and (g) of Section 12200, and shall be filed with the Secretary of State. The amount as set forth in subdivision (h) of Section 12200 shall be adjusted annually pursuant to this section in the event that the secretary agrees to administer payment under that subdivision. The payment schedule for subdivision (i) of Section 12200 shall be computed as specified, based on the new payment schedules for subdivisions (a), (b), (c), and (d) of Section 12200.

(c) The department shall adjust any amounts of aid under this chapter to insure that the minimum level required by the Social Security Act in order to maintain eligibility for funds under Title XIX of that act is met.

(d) (1) No adjustment shall be made under this section for the 1991, 1992, 1993, 1994, 1995, 1996, 1997, ~~and~~ 1998*, 2003, and 2004* calendar years to reflect any change in the cost of living. Elimination of the cost-of-living adjustment pursuant to this paragraph shall satisfy the requirements of Section 12201.05, and no further reduction shall be made pursuant to that section.

(2) Any cost-of-living adjustment granted under this section for any calendar year shall not include adjustments for any calendar year in which the cost of living was suspended pursuant to paragraph (1).

~~(e) For the 2003 calendar year, the adjustment required by this section shall become effective June 1, 2003.~~

SEC. 23. Section 12201.03 of the Welfare and Institutions Code is amended to read:

12201.03. (a) For the 1992, 1993, 1994, 1995, 1996, 1997, ~~and~~ 1998*, and 2003* calendar years, ~~or for the period of January 1, 2003, to May 31, 2003, inclusive,~~ if no cost-of-living adjustment is made pursuant to Section 12201, the payment

schedules set forth in Sections 12200, 13920, and 13921, as adjusted pursuant to Section 12201, shall include the pass along of any cost-of-living increases in federal benefits under Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code.

(b) Notwithstanding paragraph (2) of subdivision (d) of Section 12201, any adjustments made pursuant to this section to reflect the pass along of federal cost-of-living adjustments shall be included in the base amounts for purposes of determining cost-of-living adjustments made pursuant to Section 12201.

(c) Notwithstanding subdivision (a), no pass along of any cost-of-living increase in federal benefits under Subchapter 16 (commencing with Section 1381) of Chapter 7 of Title 42 of the United States Code shall be made in 1994. This provision shall not apply to those persons receiving payments pursuant to subdivisions (e), (g), and (h) of Section 12200.

(d) Notwithstanding subdivision (a), in no event shall the payment schedules be reduced below the level required by the federal Social Security Act in order to maintain eligibility for federal funding under Title XIX of the federal Social Security Act, contained in Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

SEC. 24. Section 14043.26 is added to the Welfare and Institutions Code, to read:

14043.26. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may develop application forms for enrollment and continued enrollment by dentists and may require use of these forms, or amendments thereto, upon publication in a provider bulletin, or similar instruction, without taking regulatory action.

SEC. 25. Section 14067 of the Welfare and Institutions Code is amended to read:

14067. (a) The department, in conjunction with the Managed Risk Medical Insurance Board, ~~shall~~ *may* develop and conduct a community outreach and education campaign to help families learn about, and apply for, Medi-Cal and the Healthy Families Program of the Managed Risk Medical Insurance Board, subject to the requirements of federal law. In conducting this campaign, the department may seek input from, and contract with, various entities and programs that serve children, including, but not

limited to, the State Department of Education, counties, Women, Infants, and Children program agencies, Head Start and Healthy Start programs, and community-based organizations that deal with potentially eligible families and children to assist in the outreach, education, and application completion process. *The department shall implement the campaign if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.*

(b) ~~The outreach and education campaign shall be established and implemented as of February 18, 1998.~~ An annual outreach plan shall be submitted to the Legislature by April 1 for each fiscal year *for those years for which there is funding in the annual Budget Act or other statute for the outreach and education campaign*. The plan shall address both the Medi-Cal program for children and the Healthy Families Program and, at a minimum, shall include the following:

(1) Specific milestones and objectives to be completed for the upcoming year and their anticipated cost.

(2) A general description of each strategy or method to be used for outreach.

(3) Geographic areas and special populations to be targeted, if any, and why the special targeting is needed.

(4) Coordination with other state or county education and outreach efforts.

(5) The results of previous year outreach efforts.

(c) In implementing this section, the department may amend any existing or future media outreach campaign contract that it has entered into pursuant to Section 14148.5. Notwithstanding any other provision of law, any ~~such~~ contract entered into, or amended, as required to implement this section, shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(d) (1) The department, in conjunction with the Managed Risk Medical Insurance Board, ~~shall~~ *may* award contracts to community-based organizations to help families learn about, and enroll in, the Medi-Cal program and Healthy Families Program, and other health care programs for low-income children. ~~Funding shall be contingent upon~~ *The department shall implement this subdivision if funding is provided for this purpose by an* appropriation in the annual Budget Act *or other statute*.

(2) Contracts for these outreach and enrollment projects shall be awarded based on, but not limited to, all of the following criteria:

(A) Capacity to reach populations or geographic areas with disproportionately low enrollment rates. If it is not possible to estimate the number of uninsured children in a geographic area who are eligible for the Medi-Cal program or the Healthy Families Program, proxy measures for rates of eligible children may be used. These measures may include, but are not limited to, the number of children in families with gross annual household incomes at or below the federal poverty levels pertinent to the programs.

(B) Organizational capacity and experience, including, but not limited to, any of the following:

(i) Organizational experience in serving low-income families.

(ii) Ability to work effectively with populations that have disproportionately low enrollment rates.

(iii) Organizational experiences in helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program. Organizations that do not have experience helping families learn about, and enroll in, the Medi-Cal program and Healthy Families Program shall be eligible only to the extent that they support and collaborate with the outreach and enrollment activities of entities with that experience.

(C) Effectiveness of the outreach and education plan, including, but not limited to, all of the following:

(i) Culturally and linguistically appropriate outreach and education strategies.

(ii) Strategies to identify and address barriers to enrollment, such as transportation limitations and community perceptions regarding the Medi-Cal program and Healthy Families Program.

(iii) Coordination with other outreach efforts in the community, including the statewide Healthy Families Program and Medi-Cal program outreach campaign, the state and federally funded county Medi-Cal outreach program, and any other Medi-Cal program and Healthy Families Program outreach projects in the target community.

(iv) Collaboration with other local organizations that serve families of eligible children.

(v) Strategies to ensure that children and families retain coverage and are informed of options for health coverage and services when they lose eligibility for a particular program.

(vi) Plans to inform families about all available health care programs and services.

SEC. 26. Section 14124.93 of the Welfare and Institutions Code is amended to read:

14124.93. (a) The Department of Child Support Services shall provide payments to the local child support agency of fifty dollars ($50) per case for obtaining third-party health coverage or insurance of beneficiaries, to the extent that funds are appropriated in the annual Budget Act.

(b) A county shall be eligible for a payment if the county obtains third-party health coverage or insurance for applicants or recipients of Title IV-D services not previously covered, or for whom coverage has lapsed, and the county provides all required information on a form approved by both the Department of Child Support Services and the State Department of Health Services.

(c) Payments to the local child support agency under this section shall be suspended for the 2003–04, 2004–05, and 2005–06 fiscal years.

SEC. 27. Section 14132 of the Welfare and Institutions Code is amended to read:

14132. The following is the schedule of benefits under this chapter:

(a) Outpatient services are covered as follows:

Physician, hospital or clinic outpatient, surgical center, respiratory care, optometric, chiropractic, psychology, podiatric, occupational therapy, physical therapy, speech therapy, audiology, acupuncture to the extent federal matching funds are provided for acupuncture, and services of persons rendering treatment by prayer or healing by spiritual means in the practice of any church or religious denomination insofar as these can be encompassed by federal participation under an approved plan, subject to utilization controls.

(b) Inpatient hospital services, including, but not limited to, physician and podiatric services, physical therapy and occupational therapy, are covered subject to utilization controls.

(c) Nursing facility services, subacute care services, and services provided by any category of intermediate care facility for

the developmentally disabled, including podiatry, physician, nurse practitioner services, and prescribed drugs, as described in subdivision (d), are covered subject to utilization controls. Respiratory care, physical therapy, occupational therapy, speech therapy, and audiology services for patients in nursing facilities and any category of intermediate care facility for the developmentally disabled are covered subject to utilization controls.

(d) Purchase of prescribed drugs is covered subject to the Medi-Cal List of Contract Drugs and utilization controls.

(e) Outpatient dialysis services and home hemodialysis services, including physician services, medical supplies, drugs and equipment required for dialysis, are covered, subject to utilization controls.

(f) Anesthesiologist services when provided as part of an outpatient medical procedure, nurse anesthetist services when rendered in an inpatient or outpatient setting under conditions set forth by the director, outpatient laboratory services, and X-ray services are covered, subject to utilization controls. Nothing in this subdivision shall be construed to require prior authorization for anesthesiologist services provided as part of an outpatient medical procedure or for portable X-ray services in a nursing facility or any category of intermediate care facility for the developmentally disabled.

(g) Blood and blood derivatives are covered.

(h) (1) Emergency and essential diagnostic and restorative dental services, except for orthodontic, fixed bridgework, and partial dentures that are not necessary for balance of a complete artificial denture, are covered, subject to utilization controls. The utilization controls shall allow emergency and essential diagnostic and restorative dental services and prostheses that are necessary to prevent a significant disability or to replace previously furnished prostheses which are lost or destroyed due to circumstances beyond the beneficiary's control. ~~The department's utilization controls shall not require X-rays as a condition of reimbursement for fillings for children under 18 years of age.~~ Notwithstanding the foregoing, the director may by regulation provide for certain fixed artificial dentures necessary for obtaining employment or for medical conditions which preclude the use of removable dental prostheses, and for orthodontic services in cleft palate deformities

administered by the department's California Children Services Program.

(2) For persons 21 years of age or older, the services specified in paragraph (1) shall be provided subject to the following conditions:

(A) Periodontal treatment is not a benefit.

(B) Endodontic therapy is not a benefit except for vital pulpotomy.

(C) Laboratory processed crowns are not a benefit.

(D) Removable prosthetics shall be a benefit only for patients as a requirement for employment.

(E) The director may, by regulation, provide for the provision of fixed artificial dentures that are necessary for medical conditions that preclude the use of removable dental prostheses.

(F) Notwithstanding the conditions specified in subparagraphs (A) to (E), inclusive, the department may approve services for persons with special medical disorders subject to utilization review.

(3) Paragraph (2) shall become inoperative July 1, 1995.

(i) Medical transportation is covered, subject to utilization controls.

(j) Home health care services are covered, subject to utilization controls.

(k) Prosthetic and orthotic devices and eyeglasses are covered, subject to utilization controls. Utilization controls shall allow replacement of prosthetic and orthotic devices and eyeglasses necessary because of loss or destruction due to circumstances beyond the beneficiary's control. Frame styles for eyeglasses replaced pursuant to this subdivision shall not change more than once every two years, unless the department so directs.

Orthopedic and conventional shoes are covered when provided by a prosthetic and orthotic supplier on the prescription of a physician and when at least one of the shoes will be attached to a prosthesis or brace, subject to utilization controls. Modification of stock conventional or orthopedic shoes when medically indicated, is covered subject to utilization controls. When there is a clearly established medical need that cannot be satisfied by the modification of stock conventional or orthopedic shoes, custom-made orthopedic shoes are covered, subject to utilization controls.

(*l*) Hearing aids are covered, subject to utilization controls. Utilization controls shall allow replacement of hearing aids necessary because of loss or destruction due to circumstances beyond the beneficiary's control.

(m) Durable medical equipment and medical supplies are covered, subject to utilization controls. The utilization controls shall allow the replacement of durable medical equipment and medical supplies when necessary because of loss or destruction due to circumstances beyond the beneficiary's control. The utilization controls shall allow authorization of durable medical equipment needed to assist a disabled beneficiary in caring for a child for whom the disabled beneficiary is a parent, stepparent, foster parent, or legal guardian, subject to the availability of federal financial participation. The department shall adopt emergency regulations to define and establish criteria for assistive durable medical equipment in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(n) Family planning services are covered, subject to utilization controls.

(o) Inpatient intensive rehabilitation hospital services, including respiratory rehabilitation services, in a general acute care hospital are covered, subject to utilization controls, when either of the following criteria are met:

(1) A patient with a permanent disability or severe impairment requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to develop function beyond the limited amount that would occur in the normal course of recovery.

(2) A patient with a chronic or progressive disease requires an inpatient intensive rehabilitation hospital program as described in Section 14064 to maintain the patient's present functional level as long as possible.

(p) Adult day health care is covered in accordance with Chapter 8.7 (commencing with Section 14520).

(q) (1) Application of fluoride, or other appropriate fluoride treatment as defined by the department, other prophylaxis treatment for children 17 years of age and under, are covered.

(2) All dental hygiene services provided by a registered dental hygienist in alternative practice pursuant to Sections 1768 and

1770 of the Business and Professions Code may be covered as long as they are within the scope of Denti-Cal benefits and they are necessary services provided by a registered dental hygienist in alternative practice.

(r) (1) Paramedic services performed by a city, county, or special district, or pursuant to a contract with a city, county, or special district, and pursuant to a program established under Article 3 (commencing with Section 1480) of Chapter 2.5 of Division 2 of the Health and Safety Code by a paramedic certified pursuant to that article, and consisting of defibrillation and those services specified in subdivision (3) of Section 1482 of the article.

(2) All providers enrolled under this subdivision shall satisfy all applicable statutory and regulatory requirements for becoming a Medi-Cal provider.

(3) This subdivision shall be implemented only to the extent funding is available under Section 14106.6.

(s) In-home medical care services are covered when medically appropriate and subject to utilization controls, for beneficiaries who would otherwise require care for an extended period of time in an acute care hospital at a cost higher than in-home medical care services. The director shall have the authority under this section to contract with organizations qualified to provide in-home medical care services to those persons. These services may be provided to patients placed in shared or congregate living arrangements, if a home setting is not medically appropriate or available to the beneficiary. As used in this section, ''in-home medical care service'' includes utility bills directly attributable to continuous, 24-hour operation of life-sustaining medical equipment, to the extent that federal financial participation is available.

As used in this subdivision, in-home medical care services, include, but are not limited to:

(1) Level of care and cost of care evaluations.

(2) Expenses, directly attributable to home care activities, for materials.

(3) Physician fees for home visits.

(4) Expenses directly attributable to home care activities for shelter and modification to shelter.

(5) Expenses directly attributable to additional costs of special diets, including tube feeding.

(6) Medically related personal services.

(7) Home nursing education.
(8) Emergency maintenance repair.
(9) Home health agency personnel benefits which permit coverage of care during periods when regular personnel are on vacation or using sick leave.
(10) All services needed to maintain antiseptic conditions at stoma or shunt sites on the body.
(11) Emergency and nonemergency medical transportation.
(12) Medical supplies.
(13) Medical equipment, including, but not limited to, scales, gurneys, and equipment racks suitable for paralyzed patients.
(14) Utility use directly attributable to the requirements of home care activities which are in addition to normal utility use.
(15) Special drugs and medications.
(16) Home health agency supervision of visiting staff which is medically necessary, but not included in the home health agency rate.
(17) Therapy services.
(18) Household appliances and household utensil costs directly attributable to home care activities.
(19) Modification of medical equipment for home use.
(20) Training and orientation for use of life-support systems, including, but not limited to, support of respiratory functions.
(21) Respiratory care practitioner services as defined in Sections 3702 and 3703 of the Business and Professions Code, subject to prescription by a physician and surgeon.

Beneficiaries receiving in-home medical care services are entitled to the full range of services within the Medi-Cal scope of benefits as defined by this section, subject to medical necessity and applicable utilization control. Services provided pursuant to this subdivision, which are not otherwise included in the Medi-Cal schedule of benefits, shall be available only to the extent that federal financial participation for these services is available in accordance with a home- and community-based services waiver.

(t) Home- and community-based services approved by the United States Department of Health and Human Services may be covered to the extent that federal financial participation is available for those services under waivers granted in accordance with Section 1396n of Title 42 of the United States Code. The director may seek waivers for any or all home- and

community-based services approvable under Section 1396n of Title 42 of the United States Code. Coverage for those services shall be limited by the terms, conditions, and duration of the federal waivers.

(u) Comprehensive perinatal services, as provided through an agreement with a health care provider designated in Section 14134.5 and meeting the standards developed by the department pursuant to Section 14134.5, subject to utilization controls.

The department shall seek any federal waivers necessary to implement ~~the provisions of~~ this subdivision. The provisions for which appropriate federal waivers cannot be obtained shall not be implemented. Provisions for which waivers are obtained or for which waivers are not required shall be implemented notwithstanding any inability to obtain federal waivers for the other provisions. No provision of this subdivision shall be implemented unless matching funds from Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code are available.

(v) Early and periodic screening, diagnosis, and treatment for any individual under 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(w) Hospice service which is Medicare-certified hospice service is covered, subject to utilization controls. Coverage shall be available only to the extent that no additional net program costs are incurred.

(x) When a claim for treatment provided to a beneficiary includes both services ~~which~~ *that* are authorized and reimbursable under this chapter, and services ~~which~~ *that* are not reimbursable under this chapter, that portion of the claim for the treatment and services authorized and reimbursable under this chapter shall be payable.

(y) Home- and community-based services approved by the United States Department of Health and Human Services for beneficiaries with a diagnosis of AIDS or ARC, who require intermediate care or a higher level of care.

Services provided pursuant to a waiver obtained from the Secretary of the United States Department of Health and Human Services pursuant to this subdivision, and ~~which~~ *that* are not otherwise included in the Medi-Cal schedule of benefits, shall be

available only to the extent that federal financial participation for these services is available in accordance with the waiver, and subject to the terms, conditions, and duration of the waiver. These services shall be provided to individual beneficiaries in accordance with the client's needs as identified in the plan of care, and subject to medical necessity and applicable utilization control.

The director may under this section contract with organizations qualified to provide, directly or by subcontract, services provided for in this subdivision to eligible beneficiaries. Contracts or agreements entered into pursuant to this division shall not be subject to the Public Contract Code.

(z) Respiratory care when provided in organized health care systems as defined in Section 3701 of the Business and Professions Code, and as an in-home medical service as outlined in subdivision (s).

(aa) (1) There is hereby established in the department, a program to provide comprehensive clinical family planning services to any person who has a family income at or below 200 percent of the federal poverty level, as revised annually, and who is eligible to receive these services pursuant to the waiver identified in paragraph (2). This program shall be known as the Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program.

(2) The department shall seek a waiver for a program to provide comprehensive clinical family planning services as described in paragraph (8). The program shall be operated only in accordance with the waiver and the statutes and regulations in paragraph (4) and subject to the terms, conditions, and duration of the waiver. The services shall be provided under the program only if the waiver is approved by the federal Centers for Medicare and Medicaid Services in accordance with Section 1396n of Title 42 of the United States Code and only to the extent that federal financial participation is available for the services.

(3) Solely for the purposes of the waiver and notwithstanding any other provision of law, the collection and use of an individual's social security number shall be necessary only to the extent required by federal law.

(4) Sections 14105.3 to 14105.39, inclusive, 14107.11, 24005, and 24013, and any regulations adopted under these statutes shall apply to the program provided for under this subdivision. No other

provision of law under the Medi-Cal program or the State-Only Family Planning Program shall apply to the program provided for under this subdivision.

(5) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, without taking regulatory action, the provisions of the waiver after its approval by the federal Health Care Financing Administration and the provisions of this section by means of an all-county letter or similar instruction to providers. Thereafter, the department shall adopt regulations to implement this section and the approved waiver in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. Beginning six months after the effective date of the act adding this subdivision, the department shall provide a status report to the Legislature on a semiannual basis until regulations have been adopted.

(6) In the event that the Department of Finance determines that the program operated under the authority of the waiver described in paragraph (2) is no longer cost-effective, this subdivision shall become inoperative on the first day of the first month following the issuance of a 30-day notification of that determination in writing by the Department of Finance to the chairperson in each house that considers appropriations, the chairpersons of the committees, and the appropriate subcommittees in each house that considers the State Budget, and the Chairperson of the Joint Legislative Budget Committee.

(7) If this subdivision ceases to be operative, all persons who have received or are eligible to receive comprehensive clinical family planning services pursuant to the waiver described in paragraph (2) shall receive family planning services under the Medi-Cal program pursuant to subdivision (n) if they are otherwise eligible for Medi-Cal with no share of cost, or shall receive comprehensive clinical family planning services under the program established in Division 24 (commencing with Section 24000) either if they are eligible for Medi-Cal with a share of cost or if they are otherwise eligible under Section 24003.

(8) For purposes of this subdivision, ‘‘comprehensive clinical family planning services’’ means the process of establishing objectives for the number and spacing of children, and selecting

the means by which those objectives may be achieved. These means include a broad range of acceptable and effective methods and services to limit or enhance fertility, including contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, natural family planning, abstinence methods, and basic, limited fertility management. Comprehensive clinical family planning services include, but are not limited to, preconception counseling, maternal and fetal health counseling, general reproductive health care, including diagnosis and treatment of infections and conditions, including cancer, that threaten reproductive capability, medical family planning treatment and procedures, including supplies and followup, and informational, counseling, and educational services. Comprehensive clinical family planning services shall not include abortion, pregnancy testing solely for the purposes of referral for abortion or services ancillary to abortions, or pregnancy care that is not incident to the diagnosis of pregnancy. Comprehensive clinical family planning services shall be subject to utilization control and include all of the following:

(A) Family planning related services and male and female sterilization. Family planning services for men and women shall include emergency services and services for complications directly related to the contraceptive method, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies, and followup, consultation, and referral services, as indicated, which may require treatment authorization requests.

(B) All United States Department of Agriculture, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies that are in keeping with current standards of practice and from which the individual may choose.

(C) Culturally and linguistically appropriate health education and counseling services, including informed consent, that include all of the following:

(i) Psychosocial and medical aspects of contraception.

(ii) Sexuality.

(iii) Fertility.

(iv) Pregnancy.

(v) Parenthood.

(vi) Infertility.

(vii) Reproductive health care.

(viii) Preconception and nutrition counseling.

(ix) Prevention and treatment of sexually transmitted infection.

(x) Use of contraceptive methods, federal Food and Drug Administration approved contraceptive drugs, devices, and supplies.

(xi) Possible contraceptive consequences and followup.

(xii) Interpersonal communication and negotiation of relationships to assist individuals and couples in effective contraceptive method use and planning families.

(D) A comprehensive health history, updated at next periodic visit (between 11 and 24 months after initial examination) that includes a complete obstetrical history, gynecological history, contraceptive history, personal medical history, health risk factors, and family health history, including genetic or hereditary conditions.

(E) A complete physical examination on initial and subsequent periodic visits.

(ab) Purchase of prescribed enteral formulae is covered, subject to the Medi-Cal list of enteral formulae and utilization controls.

(ac) Diabetic testing supplies are covered when provided by a pharmacy, subject to utilization controls.

SEC. 28. Section 14132.88 of the Welfare and Institutions Code is amended to read:

14132.88. (a) Notwithstanding subdivision (h) of Section 14132 and to the extent funds are made available in the annual Budget Act for this purpose, the following are covered benefits for beneficiaries 21 years of age or older under this chapter:

(1) One dental prophylaxis cleaning per year.

(2) One initial dental examination by a dentist.

(b) The following are covered benefits for beneficiaries under 21 years of age under this chapter:

(1) Two dental prophylaxis cleanings per year.

(2) Two periodic dental examinations per year.

(c) For persons 21 years of age or older, laboratory processed crowns on posterior teeth are not a covered benefit under this chapter.

(d) The department shall reduce the rate for subgingival curettage and root planing by 41 percent for all beneficiaries except those residing in a skilled nursing facility or an

intermediate care facility for the developmentally disabled. Notwithstanding Section 14105 and Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this subdivision by means of a provider bulletin, or similar instruction, without taking regulatory action.

(e) The department shall require documentation on claims to establish the medical necessity for dental restorations. Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this subdivision by means of a provider bulletin, or similar instruction, without taking regulatory action.

SEC. 29. Section 14148.5 of the Welfare and Institutions Code is amended to read:

14148.5. (a) State funded perinatal services shall be provided under the Medi-Cal program to pregnant women and state funded medical services to infants up to one year of age in families with incomes above 185 percent, but not more than 200 percent, of the federal poverty level, in the same manner that these services are being provided to the Medi-Cal population, including eligibility requirements and integration of eligibility determinations and payment of claims, except as follows:

(1) The assets of the family shall not be considered in making the eligibility determination.

(2) The income deduction specified in subdivision (f) of Section 14148 shall not be applied.

(b) Services provided under this section shall not be subject to any share-of-cost requirements.

(c) (1) The department, in implementing the Medi-Cal program and public health programs, in coordination with the ~~Major~~ *Managed* Risk Medical Insurance ~~Programs~~ *Program's* Access for Infants and Mothers component ~~shall~~ *may* provide for outreach activities in order to enhance participation and access to perinatal services. Funding received pursuant to the federal provisions shall be used to expand perinatal outreach activities. *These outreach activities shall be implemented if funding is provided for this purpose by an appropriation in the annual Budget Act or other statute.*

(2) Those outreach activities ~~required~~ *authorized* by paragraph (1) shall be targeted toward both Medi-Cal and non-Medi-Cal

eligible high risk or uninsured pregnant women and infants. Outreach activities may include, but not be limited to, all of the following:

(A) Education of the targeted women on the availability and importance of early prenatal care and referral to Medi-Cal and other programs.

(B) Information provided through toll-free telephone numbers.

(C) Recruitment and retention of perinatal providers.

(d) Notwithstanding any other provision of law, contracts required to implement the provisions of this section shall be exempt from the approval of the Director of General Services and from the provisions of the Public Contract Code.

(e) The programs authorized in this section shall be operative for the entire 1996–97 fiscal year.

SEC. 30. Section 14154 of the Welfare and Institutions Code is amended to read:

14154. *(a)* The department shall establish and maintain a plan whereby costs for county administration of the determination of eligibility for benefits under this chapter will be effectively controlled within the amounts annually appropriated for that administration. The plan, to be known as the County Administrative Cost Control Plan, shall establish standards and performance criteria, including workload, productivity, and support services standards, to which counties shall adhere. The plan shall include standards for controlling eligibility determination costs ~~which~~ *that* are incurred by performing eligibility determinations at county hospitals, or ~~which~~ *that* are incurred due to the outstationing of any other eligibility function. Except as provided in Section 14154.15, reimbursement to a county for outstationed eligibility functions shall be based solely on productivity standards applied to that county's welfare department office. The plan shall be part of a single state plan, jointly developed by the department and the State Department of Social Services, in conjunction with the counties, for administrative cost control for the Aid to Families with Dependent Children (AFDC), Food Stamp, and Medical Assistance (Medi-Cal) programs. Allocations shall be made to each county and shall be limited by and determined based upon the County Administrative Cost Control Plan. In administering the plan to control county administrative costs, the department shall not

allocate state funds to cover county cost overruns ~~which~~ *that* result from county failure to meet requirements of the plan. The department and the State Department of Social Services shall budget, administer, and allocate state funds for county administration in a uniform and consistent manner.

~~Nothing~~

(b) Nothing in ~~the provisions of~~ this section, Section 15204.5, or Section 18906 shall be construed so as to limit the administrative or budgetary responsibilities of the department in a manner ~~which~~ *that* would violate Section 14100.1, and thereby jeopardize federal financial participation under the Medi-Cal program.

(c) In administering the Medi-Cal eligibility process, each county shall meet the following performance standards each fiscal year:

(1) Complete eligibility determinations as follows:

(A) Ninety percent of the general applications without applicant errors shall be completed within 45 days.

(B) Ninety-nine percent of the general applications without applicant errors shall be completed within 60 days.

(C) Ninety percent of the applications with applicant errors shall be completed within 60 days, exclusive of the time the applicant has the application for correction of applicant errors.

(D) Ninety-nine percent of the applications with applicant errors shall be completed within 75 days, exclusive of the time the applicant has the application for correction of applicant errors.

(E) Ninety percent of the applications for Medi-Cal based on disability shall be completed within 90 days.

(F) Ninety-nine percent of the applications for Medi-Cal based on disability shall be completed within 105 days.

(G) Ninety percent of the newborn referral requests and the applications for Medi-Cal based on pregnancy shall be completed within five days.

(H) Ninety-nine percent of the newborn referral requests and the applications for Medi-Cal based on pregnancy shall be completed within 10 days.

(2) Perform timely annual redeterminations as follows:

(A) Ninety percent of the annual redeterminations shall be completed by the end of the 13th month after the initial application or anniversary date.

(B) Ninety-nine percent of the annual redeterminations shall be completed by the end of the 14th month after the initial application or anniversary date.

(d) On September 1 of each year, each county shall report to the department on the county's results in meeting the performance standards specified in this section. The report shall be subject to verification by the department.

(e) If a county does not meet the performance standards for completing eligibility determinations and redeterminations as specified in this section, the department may, at its sole discretion, reduce the allocation of funds to that county in the following year by 2 percent. Any funds so reduced may be restored by the department if, in the determination of the department, sufficient improvement has been made by the county in meeting the performance standards during the year for which the funds were reduced. If the county continues not to meet the performance standards, the department may reduce the allocation by an additional 2 percent for each year thereafter in which sufficient improvement has not been made to meet the performance standards.

SEC. 31. Notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars ($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.

SEC. 32. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to address the state budget crisis at the earliest possible time, it is necessary that this act take effect immediately.

~~amended to read:~~

~~39612. (a) In addition to funds that may be appropriated by the Legislature to the state board to carry out the additional responsibilities and to undertake necessary technical studies~~

~~required by this chapter, the state board may impose additional permit fees on nonvehicular sources within a district's jurisdiction.~~

~~(b) (1) The state board may do any of the following with respect to the collection of fees on nonvehicular sources imposed pursuant to subdivision (a):~~

~~(A) Upon obtaining the concurrence of the district, require a district to collect the fees.~~

~~(B) Establish a system in which the state board collects the fees directly.~~

~~(C) Contract with any other state agency to collect the fees.~~

~~(2) If the state board establishes a system to collect fees pursuant to subparagraph (B) of paragraph (1) or contracts with another state agency to collect the fees pursuant to subparagraph (C) of paragraph (1), each district shall provide any information necessary to ensure the accurate and efficient collection of the fees from nonvehicular sources.~~

~~(c) The permit fees imposed pursuant to this section shall be expended only for the purposes of recovering costs of additional state programs related to nonvehicular sources. Priority for expenditure of permit fees collected pursuant to this section shall be given to the following activities:~~

~~(1) Identifying air quality related indicators that may be used to measure or estimate progress in the attainment of state ambient air standards pursuant to subdivision (f) of Section 39607.~~

~~(2) Establishing a uniform methodology for assessing population exposure to air pollutants pursuant to subdivision (g) of Section 39607.~~

~~(3) Updating the emission inventory pursuant to Section 39607.3, including emissions that cause or contribute to the nonattainment of federal ambient air standards.~~

~~(4) Identifying, assessing, and establishing the mitigation requirements for the effects of interbasin transport of air pollutants pursuant to Section 39610.~~

~~(5) Updating the state board's guidance to districts on ranking control measures for stationary sources based upon the cost effectiveness of those measures in reducing air pollution.~~

~~(d) The permit fees imposed pursuant to this section shall be collected from nonvehicular sources that are authorized by district permits to emit 250 tons or more per year of any nonattainment pollutant or its precursors.~~

~~(e) The permit fees collected by a district pursuant to this section, after deducting the administrative costs to the district of collecting the fees, shall be transmitted to the Controller for deposit in the Air Pollution Control Fund.~~

~~(f) On or before January 1 of each year, the state board shall report to the Governor and the Legislature on the expenditure of permit fees collected pursuant to this section and Section 39613. The report shall include a report on the status of implementation of the programs prioritized for funding pursuant to subdivision (c).~~

~~SEC. 2. Section 39613 is added to the Health and Safety Code, to read:~~

~~39613. The state board shall impose a fee on any consumer product, as defined in Section 41712, sold in the state and any architectural coating sold in the state if a manufacturer's total sales of consumer products or architectural coatings will result in the emission in the state of 250 tons per year or greater of volatile organic compounds. Revenues collected from the imposition of this fee shall be used to mitigate or reduce air pollution in the state created by consumer products and architectural coatings, as determined by the state board, and shall be expended solely for those purposes.~~

~~SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because in that regard this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

~~However, notwithstanding Section 17610 of the Government Code, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code. If the statewide cost of the claim for reimbursement does not exceed one million dollars~~

~~($1,000,000), reimbursement shall be made from the State Mandates Claims Fund.~~

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